SYSTEMS UNIT

INDIANA HEALTH COVERAGE PROGRAMS

Executive Level Overview

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Section 1: System Architecture

Hardware Platform Overview

Refer to the following high-level application architecture diagram for these discussions.

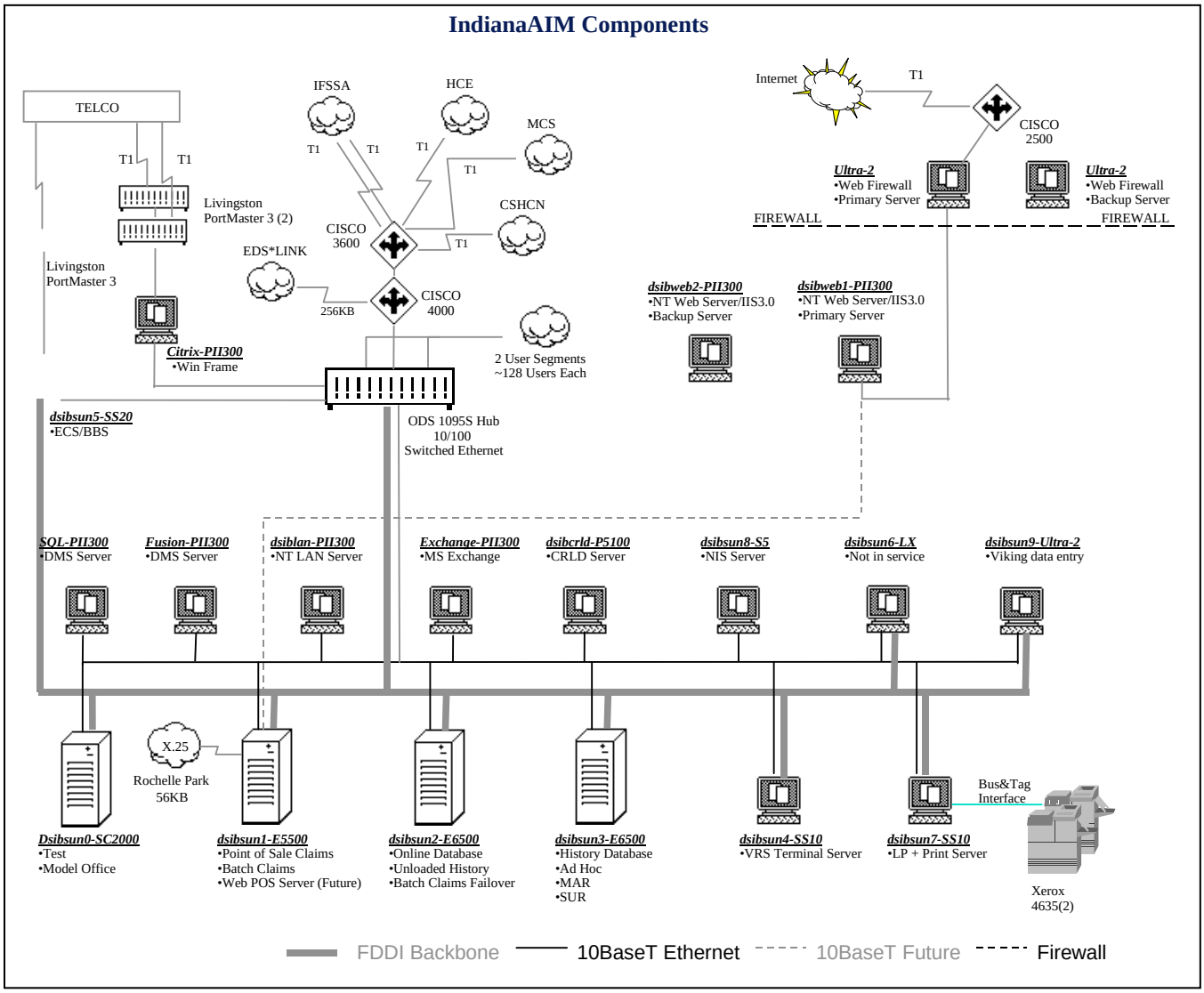

Figure 1.1 – Indiana*AIM* Components

Server Configuration

- 1 Sun Ultra Enterprise 5500
- 2 Sun Ultra Enterprise 6500's
- 1 Sun SparcCenter 2000
- 3 Sun Ultra II's
- 1 Sun SparcStation 20
- 2 Sun SparcStation 10's
- 1 Sun SparcStation 5
- 1 Sun SparcStation LX
- 6 Compaq Prolient Servers
- 3 Lucent Portmaster Remote Access Servers

LAN Configuration

There are two Cisco modular routers installed at the account; a 4000 router that connects the EDS account employees to EDS*LINK, and a 3600 router that connects the State and all other outside agencies to the Indiana Title XIX network. Each router can have up to three processor modules installed in it. The 4000 router currently has one single Ethernet network processor module and one dual serial network processor module, providing EDS*LINK access to the account. The 3600 router provides routing and connections between the outside agencies as well as between the two user Ethernet segments and the server Ethernet segment. It currently contains two dual port Ethernet network processor modules and has one remaining slot open for future expansion. One backup 3600 router is maintained on site for fail over.

All network connections are handled by an Optical Data Systems (ODS) 1095S Infinity Intelligent Switchable Hub and 2 ODS 6007 hubs. The 1095S is a 12 slot hub with dual power supplies, hot swappable module technology, along with Ethernet, Fiber Distributed Data Interface (FDDI) and token ring backplanes, five 32 port and one 24 port 10BaseT switched Ethernet modules (1 slot each) are installed in the hub allowing up to 184 Ethernet connections. One FDDI processor module (2 slots) and two 6 port MIC user module (2 slots) are installed allowing up to 12 FDDI connections. A Segment Switch management module (1 slot) is installed to provide LAN management and diagnostic capabilities. The 2 6007 hubs, located on the 9th and 10th floors, are configured to support 120 Ethernet connections on the 10th floor and 88 Ethernet connections on the 9^{th} floor. The 6007 hubs also have dual power supplies and hot swappable modular technology.

Printer Configuration

Printed output from the *AIM* MMIS will be handled by two Xerox 4635 laser printers. Both of these printers are capable of continuous output at speeds up to 135 pages per minute in either simplex or 67 pages in duplex mode. The features of these printers include 600 x 600 DPI resolution, multiple input feeders and output stackers, downloadable forms/graphics support, and multiple font support in sizes from 4 to 24 points. In addition to these features, one of the 4635 printers is PostScript compatible and is used to generate provider bulletins and manuals.

The 4635 printers are controlled by Digital Controls LpPlus software running on a Sun Sparcstation 10. The LpPlus software provides a GUI interface solution for controlling and administering print spooling, print queuing, queue management, print security, operator security, job tracking, job accounting, and load balancing of the 4635s. The LpPlus solution allows account users to print to the 4635s from PCs.

There are several HP LaserJet printers attached to each LAN segment for the account users to access from their PCs. An HP Draftmaster MX plotter that has an eight pen capacity and can handle media sizes up to 36 inches wide is also attached to the LAN.

Network Overview

Statewide Network

The various state agencies such as FSSA and CSHCN are connected to the *AIM* MMIS via point to point DS1 circuits provided by Time Warner. These circuits are monitored by personnel at Time Warner to guard against any break in service. In the event a break is detected, the proper personnel at EDS is notified immediately.

Account Network

The account network is made up of two 10BaseT Ethernet segments, each having up to 244 users. The account users are divided between these two segments, to reduce the amount of users per Ethernet segment that also reduces the amount of traffic on each segment. This provides better response times, some fault tolerance to the network and allows for future expansion. The account is connected to EDS*LINK via a Cisco 4000 router and to the state agencies via the Cisco 3600 router. A 256Kb link to the Dayton IPC provides global EDS*LINK access. The state agencies are connected to one of the two-Ethernet segments, and can also be placed on a separate Ethernet segment if the data traffic becomes too heavy. The NT file server resides on both of the Ethernet segments with one 100MB uplink from the hub per segment.

Sun Server Network

The Sun servers are connected by two separate backbones. The first backbone is a 10/100 BaseT Ethernet segment that can have up to 62 hosts attached. This segment is isolated from account LAN traffic, reducing the network overhead on this segment. User applications and SEs interact with the *AIM* MMIS and servers via this segment. The second network segment is an FDDI segment that can have up to 62 hosts attached. The FDDI segment is used for communication and file transfer between the Sun servers due to its high speed, high reliability fiber optic technology. The *AIM* applications running on the Sun servers can fall back to Ethernet communication if the FDDI network fails.

POS X.25 Network

Point of Sale (POS) transactions occur over an X.25 connection between one of the Sun Ultra Enterprise 5500 and the Aurburn Hills Datacenter. The physical connection is made by RACAL Excalibur modems. Since X.25 is a synchronous serial protocol, these modems require a 56Kbs Leased Line from Indiana to Aurburn Hills and 56Kbs ISDN line to support the dial backup capabilities. In order to use the POS system, a pharmacy or other provider needs either the EDS NECS or PES software for the local PC or the GCC or Envoy (other service providers) software. This software cause the modem attached to the provider's PC to dialup a connection to the X.25 cloud. The transaction is routed through the X.25 cloud to Auburn Hills DASS system. The DASS system sends the transaction through the Excalibur modems to the Sun 5500. The normal transmission route is through the leased line circuit. However, if there is ever a problem with the leased line, the RACAL modems automatically initiate the dial backup circuit and continue to send transactions through. Therefore, unless the entire trunk line from Aurbrun Hills to the Michigan phone central office or a similar circumstance in Indianapolis occurs, the X.25 circuit should always be up. On the Sun 5500, the posind program receives X.25 packet data from the Sun Solstice X.25 software and routes the POS transactions to the appropriate Indiana claims engine service.

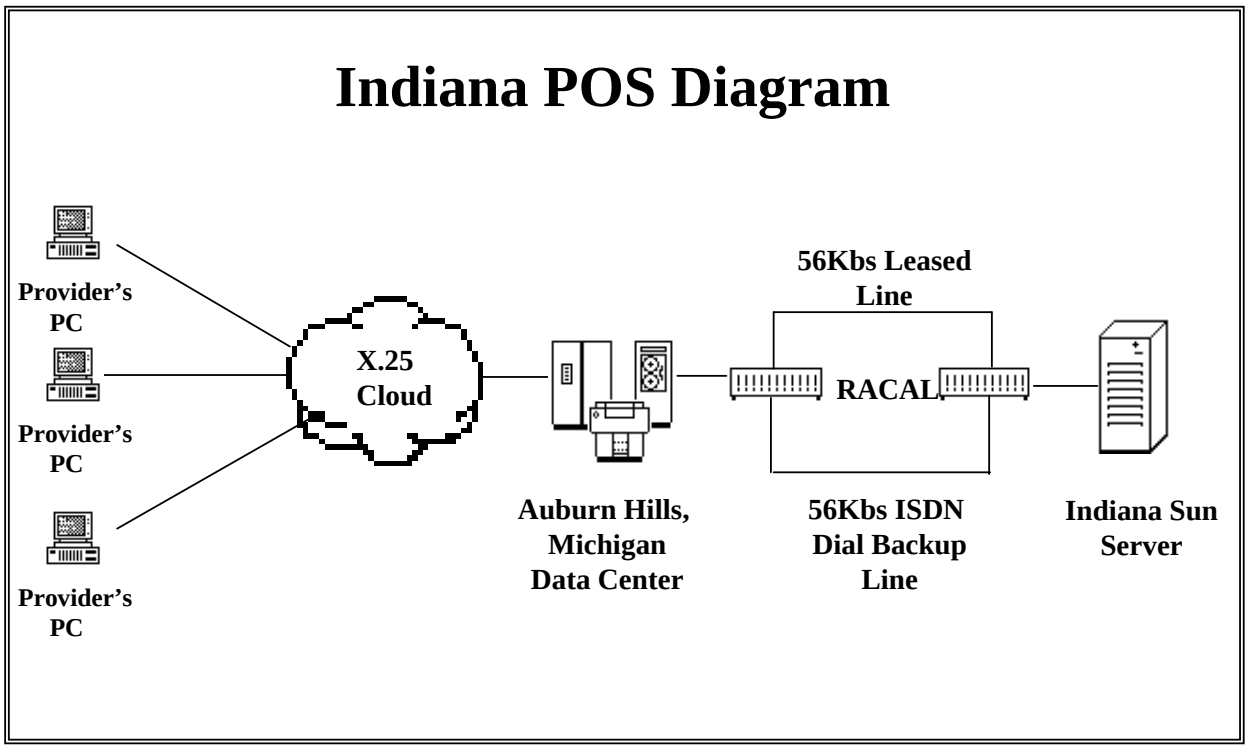

Figure 1.2 – Indiana POS Diagram

Section 2: Application Architecture

Overview

This document provides a high level overview of the claims engine design. The overview section identifies major points in the design of the Indiana architecture. Subsequent sections address the major points in more detail describing implementation options and the pros and cons of each. Refer to the following high-level application architecture diagram for this discussion.

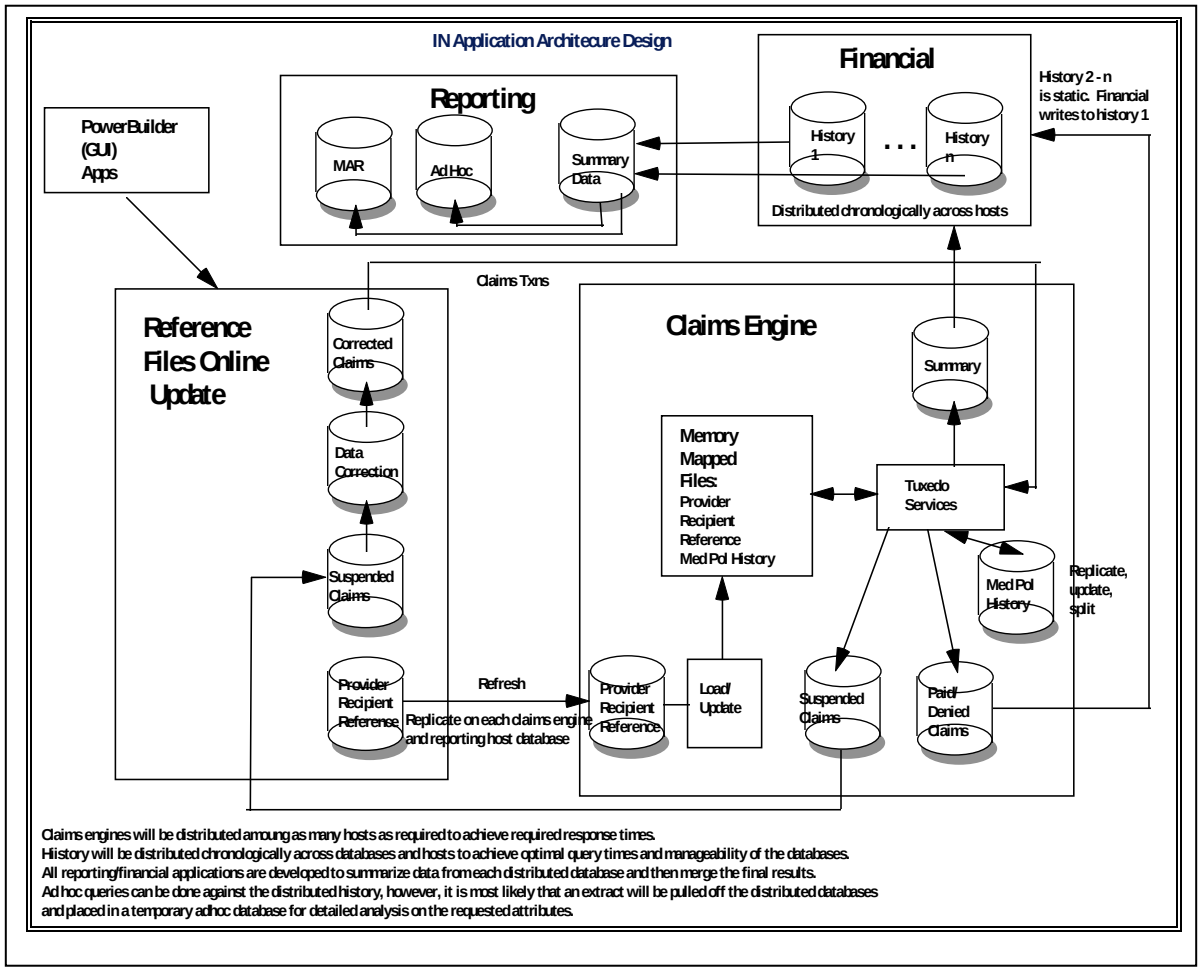

Figure 2.1 – Indiana Application Architecture Design

The goal for Indiana*AIM* was a scalable system. This required a distributed architecture that allows the system to run in parallel across multiple nodes. The concepts of distributed processing as well as distributed data are part of the Indiana*AIM* design.

Distributed Processing

In the Indiana*AIM* system, distributed processing is used. What this means is that processing is distributed over multiple processes and when necessary, multiple nodes. This allows an increase in throughput by processing multiple transactions in parallel. Given the high transaction rate to be met, a distributed processing design insulates the application code from needing to know where the code is processing. In this way, if one computer node, another node becomes overloaded another can be added to the system and the load can be redistributed without impacting the application code. If one node experiences failure, processing can be redistributed among the working nodes. Designing applications to run in parallel, instead of the traditional serial mode, is an important aspect to understand when downsizing to more cost-effective platforms. Please refer to the Claims Engine, Reporting, and Financial sections of this document for the specifics of how distributed processing is implemented for each part of the system

Distributed Data

In order to use distributed processing, the data used in the application code must be distributed as well. The use of distributed data often causes the size of a single database to become unmanageable. This creates the need for various types and combinations of data distribution:

- Replicated Data

  Replicated data is copies of data. This technique is used for performance when it is not advantageous to access a single table. For instance when processing is distributed across multiple nodes, some of the claims processing needs access to all rows in some tables, it precludes using horizontal partitioning.

- Horizontal Partitioning

Horizontal partitioning takes various rows out of a single table and creates multiple tables. This technique is used to facilitate the management of tables as well as yielding a performance gain because smaller tables can be queried.

- Vertical Partitioning

An analysis is made to take various columns out of tables and create multiple tables out of a single logical entity. An example of this is the claim itself. For the processing of a claim, only a subset of attributes is required. The claims are vertically partitioned out into a separate medpol history table used for the claims processing. Other attributes are written to a different table. It should be noted that in this case, the medpol history is also *horizontally partitioned* by claim type, and is *replicated* across all nodes.

Claims Engine

The Indiana claims engine is designed to allow the distribution of data and processing. Current architecture allows multiple claim engines to be networked together. Each engine is capable of processing a claim for any recipient. Under this architecture, if any node on the network fails, other claim engines begin processing claims destined for the failed node. This removes the need for additional software at the O/S and database level.

Claims being processed require access to reference, provider, and recipient information. The application has been designed so that updates from the online system do not occur until a pre-determined time. Additionally, the only data updated by the claim engine is claim history and suspended claims. This allows the claim engine to "cache" most of the read only information into memory. A technique called memory mapping is used, providing a scalable solution that lock into core only pages that are frequently accessed.

Claim history must be synchronized across all of the claim engines. This is necessary because any node can process a claim for a recipient and audits require access to all of a recipient's history. The application has been designed so audits run against medical policy history, which is the only data that must be kept in synch. The synchronization is accomplished through the use of the Tuxedo XA interface. When the application attempts to update the medical policy history, it calls a Tuxedo service that coordinates the update.

The claim engine provides non-stop processing except for the technique used to refresh Reference, provider, recipient, and med pol history files. The technique designed for the Indiana*AIM* system allows files to be refreshed quickly. Refreshing the files is a three-step process. Refer to the *Refreshing Data Files* section for details about the technique.

Distributed Transaction Processing

The Indiana*AIM* system allows for the distribution of processing across several systems. In order to support the distribution, the issues below must be considered:

- History claims must remain static once written
- Recipient, Reference, and Provider files must not be updated during the processing of a claim.
- The claim must be made available to the appropriate processing nodes upon adjudication of the claim.

The design of the application functions such as spend down or prior authorization does not need to update these files. This is accomplished by implementing the functions as audits instead of keeping counts in the reference files. Other functions

such as adjustments can be implemented through the use of pointers to the current claim in history.
An appropriate routing algorithm addresses the third issue. Claims can be routed two ways for processing. Claims can be routed by recipient ID or by any available node. Each of these routing algorithms are impacted by system availability, load balancing, and scalability.

- Routing by Recipient ID

  Routing by recipient ID requires that all claims for a given recipient range be processed on a pre-determined node. This has the advantage of keeping all processing local, which speeds up processing. Additionally, it is more scalable than routing by any available node because the amount of data contained on a single node is considerably less. The disadvantage is that load balancing by recipient ID range requires constant monitoring to ensure that the load is spread evenly across nodes. It also presents an availability problem if one of the nodes goes down. The system could not process an entire range of recipients for the duration of the downtime.

- Routing to Any Available Node

  Routing to any available node allows claims to be processed on any node regardless of recipient ID, claim type, or other arbitrary distribution. This has the advantage of load balancing by the capability of the machine. This allows us to mix large and small machines and makes maximum use of every machine on the network. If any mode goes down, all claims continue processing. The disadvantage of this option is that claims processed for a recipient must be replicated across all nodes in the network. When the application is updating medical policy history, the history must be updated on all nodes in the network. Machines added into the network must be slightly larger because a complete history file must be kept on each node.

Recipient Blocking

The processing of claims must be coordinated across all nodes in the Indiana network. Coordination must occur because a claim for the same recipient ID cannot process in parallel. If this happens, unpredictable results are obtained in the audit process.

The diagram below illustrates how client and server processes will interact.

The client process in the diagram is shown communicating with claim services through the *recipient blocker* process. There is one process for each recipient that must run parallel. Additionally, all of the processes must run on the same system. This allows them to coordinate recipients via control structures located in shared memory. Given the claim volume of approximately 500,000 claims per week, and estimating an average response time of five seconds per claim, approximately 30 of processes must be running to support the claim volume.

The processes keep a shared table of recipients that are actively processing in the system. When it is OK to process a recipient, the transaction is sent to the appropriate claim service. Upon completion of the claim service, a response is returned to the *recipient blocker* indicating that the next recipient in line for services can begin processing. The control structure is updated and a response is sent to the client process.

This technique of blocking causes problems in the event of a system failure. If the machine running the *blocker* processes fails, then *all* of the transactions in flight are aborted and the client processes receive a notification of this event. It is then up to the system administrator to bring up the *blocker* processes on an alternate node. Failover does not occur automatically because of the many chances for error. Clients must re-submit any claims were submitted during the time frame. This is handled in the client process by an algorithm that retries the claim a specified number of times and then fails the claim if it cannot be processed. Refer to the section that discusses refreshing of the claims database for additional information on the client retry process.

Caching Read Only Tables

The Indiana*AIM* system makes extensive use of system memory to provide for caching of the read only tables. There are three ways to accomplish caching:

- Database cache
- Shared Memory Segments
- Memory Mapped Files

A description of each of these techniques is provided below. We currently have a combination of the first and second options implemented for Indiana. However based on the advantages of memory mapping, they will be changed to take advantage of this.

- Database Cache

  The use of the database cache is the simplest method of caching, however it is also the most expensive in terms of CPU overhead. Going to the database for static data is very time intense.

- Shared Memory Segment

  Data can be placed into a shared memory segment and accessed directly by the claims system. This technique is used to dramatically reduce the amount of time required to access read only data. The drawback to this approach is that there must be enough physical memory to bring in all of the data and space must be reserved in the sway file to create the shared memory segment. The drawbacks present the following problems:

  - Adequate memory cannot be put on the machine to map the entire medical policy history file. The applications must be coded to look in shared memory, the large medical policy database tables, and finally the current medical policy tables.
  - To establish a test environment for the applications a large amount of memory must be configured for the test and model office systems.

- Memory Mapped Files

  Memory mapping is an operating system tool that allows a process to map a flat file into the address space. The process can then access the data directly without intervention of the operating system. This technique is similar to shared memory except that the memory issues are not present.

  Applications are simplified because it is not necessary to distinguish between *shared memory history* and *large medical policy database tables*. The applications must only look for history in the *current medical policy tables* and the *memory mapped medical policy files*.

Physical memory is not needed to bring in all of the data. Physical memory is only needed for the portion of the file that will be locked into core. The remainder of the file is paged in by the operating system when it is needed. The files are organized so the frequently accessed data is contiguous. Whenever a process tries to access something outside of the locked data, the operating system automatically pages in the data. This allows a test and model office machine with less physical memory since data is not locked on the machine.

Refreshing Data Files

Database tables within the claims engine must be refreshed from the online system on a daily basis. Updates that occur in the online system are not immediately reflected in the claims system for the following reasons:

- Tables are not refreshed in *real-time* because claims must be consistently adjudicated throughout the day. If data within the reference files changes, a claim would require an effective date and time stamp on each row so that claims would know when to begin using the new data.
- Claims processing would be extremely difficult to distribute if only one copy of the reference tables could be used. The claims engine would need to go across the network to access the data resulting in slow response time.
- Reference files would become a serious bottleneck in the processing of claims. Performance is limited by the maximum number of selects sustained against a single set of tables.

Refreshing of reference, provider, and recipient tables is a four-step process. This process is illustrated in the diagram on the following page.

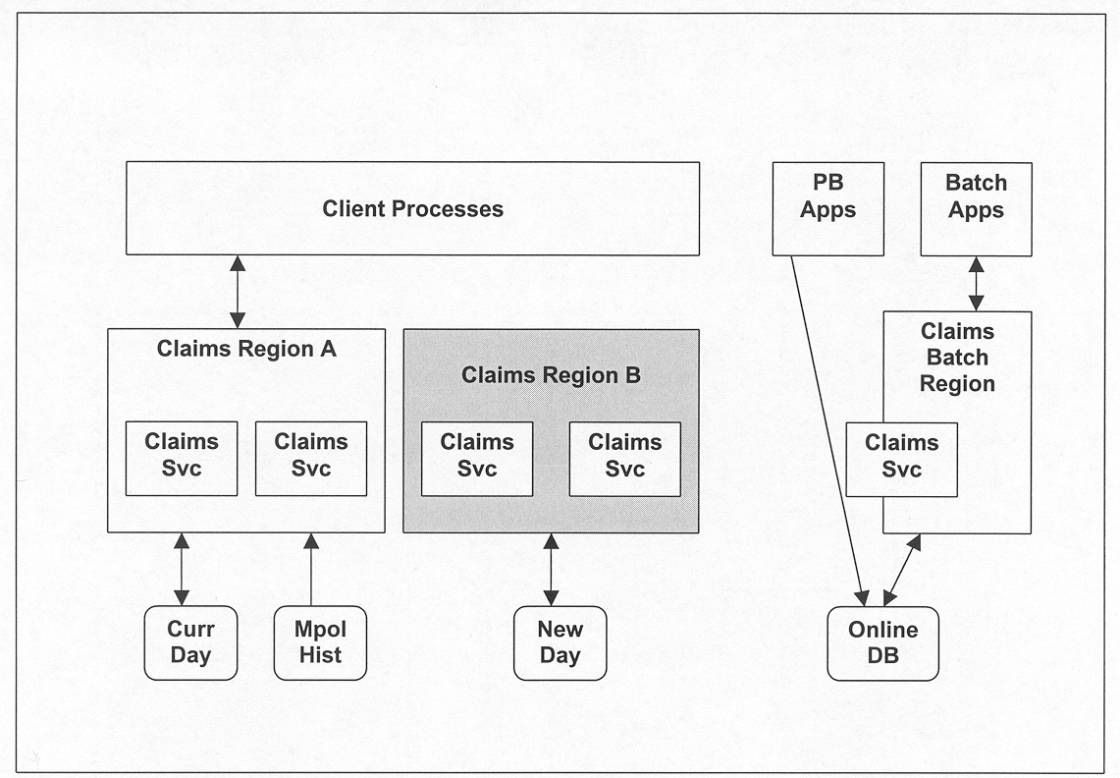

Figure 2.2 – Refreshing Data Files Process

Refresh of Reference Tables

The first step in the refresh process is to obtain a new copy of the reference and provider tables and place in the Tuxedo installation B. This is accomplished through an export of the necessary tables in the online database. A complete list of the exported tables is found in Appendix A. The exported data is then transported to each of the claims engine systems. Timing and the export must be resolved in this step. The timing of the data movement depends on any batch jobs that must be run in the system. For example, the recipient eligibility updates must be applied before the refresh can begin. The application teams must define all of the processes so an appropriate schedule can be worked out. The method used to export data from the online system must be established. The easiest technique to use is to export all tables that have been modified and can be time consuming for larger tables. Another method is to apply only modifications that have occurred in the online system accomplished by using the audit trail information. A module must be developed to do this. The second step in the refresh process is to bring up tuxedo installation B.

This step starts a duplicate copy of the claims engine on each node. The only difference between the two installations at this point is the database they run against.

The tuxedo services run against the new copy of the database. The only data that is pulled from the old database is the medical policy history. Until the medical policy history has been rebuilt, the claim services audits against both copies. The services pull data from both databases by enabling a module on the Jackson diagram that reads data from the old medical policy history. Since the data is physically located in another database, a database link must be used to provide a *transparent* access to the data. The third step, illustrated below, is to *unadvertise* all of the services in Tuxedo installation A.

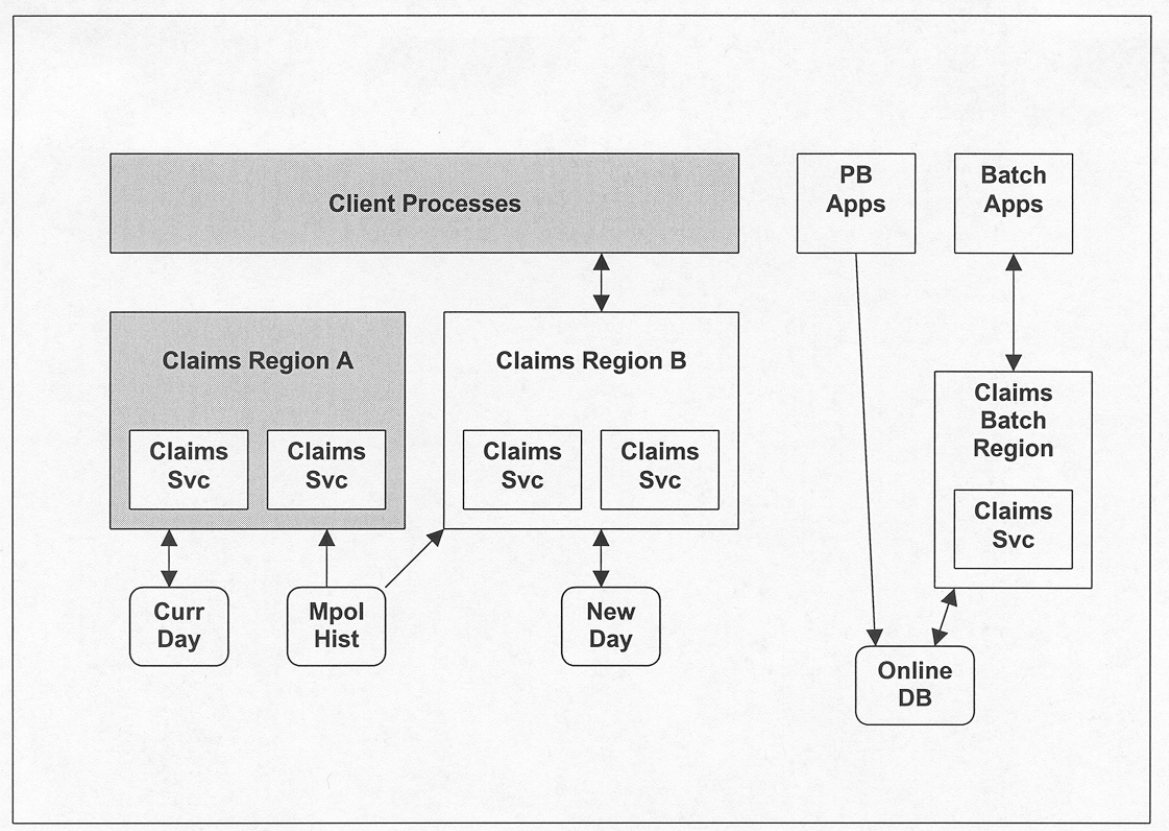

Figure 2.3 – Unadvertise Services in Tuxedo Installation A

This forces all of the clients to fail when a subsequent transaction is started and forces a client into retry logic. The logic must be written to retry a specified number of times on the same tuxedo installation and then to try and connect to the alternate tuxedo installations. This allows the default error handling routines to handle both a switch type function and an error indicating the server system actually crashed. Example code segments are supplied in Appendix B of this document.

During this time frame, transactions that are submitted to Tuxedo installation B must be blocked until all transactions in installation A have completed. This ensures recipient routing and audits function correctly. This is handled within the blocking

process logic. Processing logic is coded to wait until a flag is set in a shared memory region, indicating that processing can continue.

Refresh of Medical Policy Data

At this point all of the database tables are refreshed and all of the clients are running against the new copy of the claims system. The only remaining data to be updated is medical policy data. Medical policy data is located in three places:

- Current day tables
- Previous day tables
- Memory mapped files.

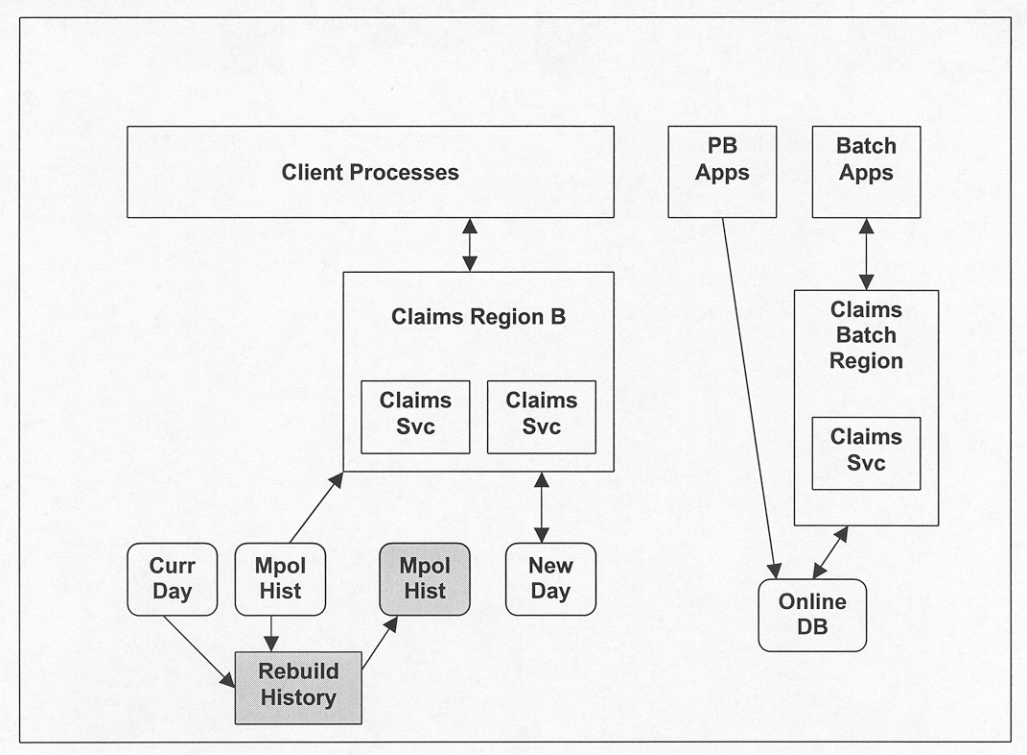

Figure 2.4 – Refresh of Medical Policy Data

A merge process must be run to take the previous day medical policy data and the history data and rebuild it into a new set of data files. Any adjustments that have occurred must be removed from the master medical policy file. Once the merge is completed, two things must occur:

- The medical policy data must be re-mapped.
- The module that is reading from the previous day medical policy must be disabled.

This is accomplished by changing a control structure that all of the services have mapped in. At the beginning of any claim transaction, the control structure is examined to determine if new data files should be mapped into the services address space. If this flag indicates that the files should be remapped, the service disables the appropriate module on the Jackson diagram, unmaps all of the current data files, and remaps the new version of the data files.

Once completed, the old version of the data files is removed and any activity that occurs within the old version of the database can begin. The diagram below depicts the modules that are running at the end of the process.

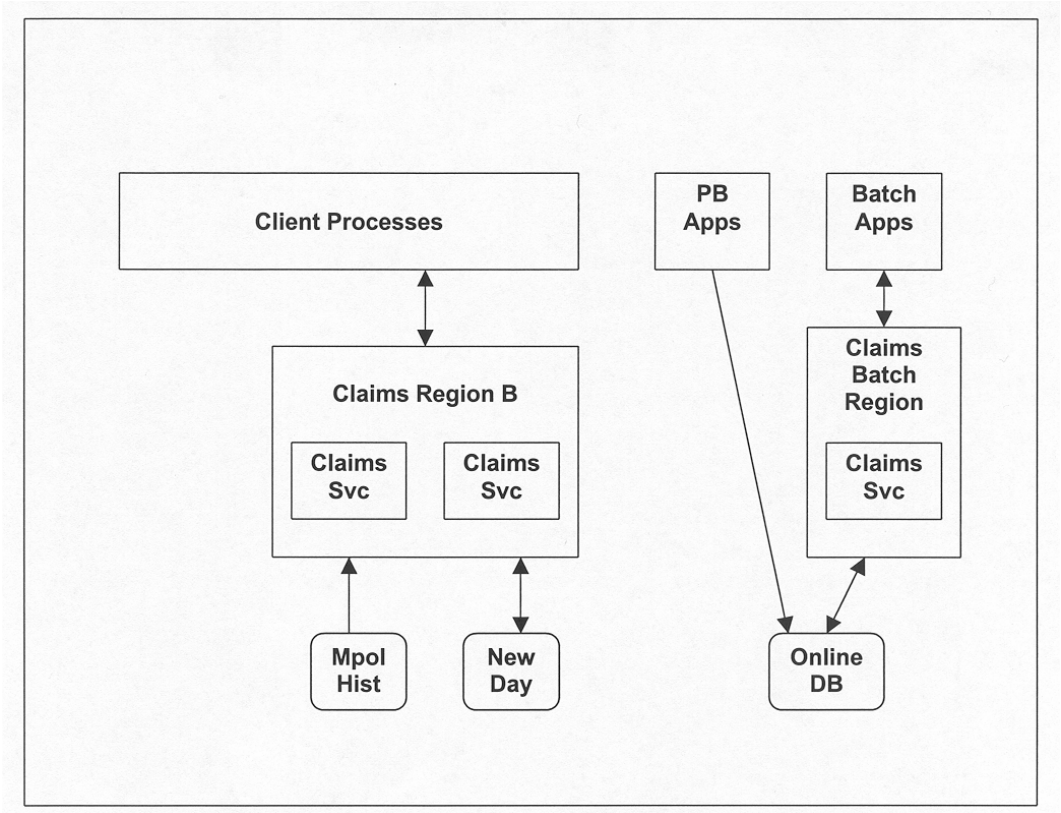

Figure 2.5 – Modules Running at end of Process

Online Processing

The Indiana*AIM* database receives updates from many sources throughout the day. Most database objects are updated by applications developed with PowerBuilder. Other database objects are updated by Tuxedo transactions or batch transactions. Claims are created by Tuxedo transactions running on one of the claim engines. The database objets used to process claims reside in a database on a primary machine. This machine is labeled as *Reference Files Online Update* on the *Application*

Architecture Design diagram. This machine processes non-online applications, such as RECIPIENT updates from ICES.

The updates that affect claims processing must be applied to the *memory mapped* files of each claim engine. This takes place during low-claim activity hours. It is necessary, however, to provide some type of emergency memory update transaction whenever the regularly scheduled updates are inadequate.

Suspended claims are consolidated from the claim engines in this machine as well. After consolidation, suspended claims are scheduled for correction by claims examiners. Once corrected, a claim is queued to be processed by a claim engine. If the claim suspend again, it is necessary for the suspended claim to be consolidated into the main suspense database and rescheduled for correction.

When paper claims, which makes up about 20 percent of total claim volume, are received, claim activation is created in this machine. When the claim engines receive the REI claims, the claim ICN is matched against activation. If the activation exists a receipt record is inserted in the claim engine database. The receipt records are used later to reconcile with the activation records to produce a claim inventory report. Claim activation must be made available to all claims engines, and paper claims must be processed in the machine where the activation is entered. Replication of activation in all claim engines is not a problem because of the low volume. Most of the activation activity is an insertion type activity and modifications to activation are infrequent.

Reporting

In order to improve response time and maintain tables in a manageable size for DBMS maintenance, the claim history is horizontally partitioned chronologically. This allows many static databases and minimizes the total time necessary for routine DBMS maintenance. The databases also have the flexibility to spread across multiple nodes for performance.

The high level design of all reports includes a driver module to start up child processes across all nodes and databases that might have pertinent data. The drive module is the only module that is aware of multiple nodes. The child processes are not aware of other nodes and databases. The driver module takes the results from all the child processes and intelligently merges the results for the final output. This makes the reporting system scalable and as the size of data to be retained increases. Additional nodes can be added to the system without impacting the application code.

Ad hoc queries are more difficult using distributed data, but given the size, would also be impractical. This requires the design a smooth extract process for data that can then be loaded into small, temporary tables for statistical analysis.

Financial

Since the financial system creates the claim history records, this system must be able to add claim records to different databases based on the chronological partitions in place at the time the record processes.

Section 3: Application Services and Utilities

Wide Area Network Security

State Network

Access to the state network is restricted by required IP addresses. Only machines that must have access to the State computers can pass through the routers.

Routers

Setting only required IP addresses controls access. Only machines that must access the *AIM* SUN machines can pass through the routers.

Sun Server Network

- Empty /etc/hosts.equiv file

  This is a file that allows remote access to computers. This file bypasses the standard password-based authentication mechanism. To maintain system security, care must be taken in creating and maintaining these files. Keep this file empty unless remote shell is required or scripts must run in background using rlogin or rsh. If an entry has to reside in this file it must be a netgroup.

- No personal rhosts files

  This file also allows access to remote computers. This file bypasses the standard password-based authentication mechanism. To maintain system security, care must be taken in creating and maintaining these files. No individuals have files containing computers that can be connected to. Connection to computers within Unix is controlled by the system.

- NFS shared files use netgroups

  All files available to other machines use a list of specified computers that can access those files. NFS allows files from computer A to be seen as local to computer B. By using netgroups, only specified computers can make the nonlocal files seem local.

- No $HOME/.netrc files with unencrypted passwords for automatic logon using telnet and ftp

  These files are used to allow automatic logon to the Unix system by listing the logon and password in a file in the home directory of the user. If the password is left unencrypted anyone able to read the file can obtain the password of the user.

- No "tftp" command

  This command allows the transfer of files to and from remote computers. This command does not require an actual logon to the remote system so there is no validation of the ID.

- No "uucp" except on ECS Sparc 20 (required there)

  This command allows a user to copy files to and from other computers and to execute commands on other computers. On ECS Sparc 10 allow only required commands, cross check remote computer name with the log-on ID. Also restricts read and write to required directories.

Local Area Network Security

NT Server

- User ID required (with password)

  Access to the LAN requires a unique user ID and password. Passwords expire automatically after a specified time period.

- Access by file permissions

  Access to files is controlled by file permission and by group level authority. If a user is not a member of a particular group then access to files controlled by that group is denied.

PC Level

- Password protected screen savers

A Windows activated screen saver displays after a specified interval of no use. The Windows software also contains a password protection option on the screen saver that should be used.

Unix System Security

When logging into the Sun computers an unauthorized use message displays. This message state that unlawful use is prohibited.

NIS, DNS

- Unique log-ons

Access to the Unix environment requires a user ID and password. All users that require access to Sun drives but do not need logon access have logons set to /bin/false which prohibits logging onto Unix.

- Passwords

  All Unix passwords require at least one numeric character and must be a specific length.

Root Access

A unique password is required for access to the root ID. Log-on to the root ID is logged.

Group IDs

- File access based on groups

  Users can access files on the Unix system only if the ID is a part of a required group. In some cases this restricts reading, writing, and execution of a file.

Permissions

File permissions are the same in test, mod, acc, and prod. The only difference is the group.

Directory level	Owner	Group
development	User ID	dsibse
test	dsibtest	dsibset
mod	dsibmod	dsibsem
acc	dsibacc	dsibsea
prod	dsibprod	dsibsep

Figure 3.1 – Permission Levels

DIR	SUBDIR	Owner	Group	Permissions
HOME		Userid	dsibse	drwxr-x---
Test		dsibtest	dsibset	drwxr-x---
	o doc	dsibtest	dsibset	drwxr-x---
	o fld	dsibtest	dsibset	drwxr-x---
	o hlp	dsibtest	dsibset	drwxr-x---
	o template	dsibtest	dsibset	drwxr-x---
	o ubb	dsibtest	dsibset	drwxr-x---
	o view	dsibtest	dsibset	drwxr-x---
	o dproc	dsibtest	dsibset	drwxr-x---
	o src	dsibtest	dsibset	drwxr-x---
	o ubin	dsibtest	dsibset	drwxr-x---
	o inc	dsibtest	dsibset	drwxr-x---
	o data	dsibtest	dsibset	drwxr-x---
	o job	dsibtest	dsibset	drwxr-x---
	o uobj	dsibtest	dsibset	drwxr-x---
	o clmuobj	dsibtest	dsibset	drwxr-x---

Figure 3.2 – Directory and Subdirectory Permissions

Dial-up Access

- Unix ID

  A unique ID and password is required to access the Unix environment.

- Termination of call

Termination of a modem connection to the remote access server ends communications.

Application Security

PowerBuilder

- MetaSolve

  Use of this package displays a log-on screen. This logon screen enforces a timeout after a specified amount of time without activity and an automatic logoff after three incorrect log-on attempts

- Screen-level security

PowerBuilder applications enforce screen level security. The application does not allow modification of a screen without the appropriate authority.

- Field level security

  The PowerBuilder applications enforce field level security on specified screens. The application does not allow modification of various fields without the appropriate authority.

- General security

  An ID and password is coded into the application allowing the application to read the specified database. The application verifies the ID and password. If the ID and password is valid the application sets a database role to allow processing to continue.

Adhoc Tool Access

- PowerViewer

  This is a DOS only application with no Unix access that allows a database to be viewed. Access is based on the PowerViewer role.

- SQL*Plus

  This is a database tool that manipulates a database. Access is based on user database access and any role the user is given the password to.

Version Control

- VSC

  This is a version control and promotion utility that allows versioning of Unix files. File modification is not allowed once it is promoted. Promotion to model office, user acceptance, and production are restricted and requires specific user authority. The ability to change ownership of a file and to remove a file from the system is restricted.

DBMS Security

User access

All user access is password protected.

- DBAs

Full access to the databases, each individual with DBA access must use or change to the oracle ID or the dsibdba ID, which allows for logging the IDs. DBA IDs cannot be typed in at the login prompt.

- EID/CYCLE

  Select, update, insert, or delete any table in the database. Ability to execute any procedure creates temp tables, used for emergency situations, cycle activity, and Tuxedo.

- Developers

  Select any table in the database.

- BOOTUP

  ID used by PowerBuilder applications to log on to the Oracle DBs check user access prior to the actual user logon.

- All Others

  Each ID has connect and resource access to the database, all other access is by roles.

Roles

- PowerBuilder Role

  Select, update, insert, or delete any table in the database, able to execute any procedure, able to create temp tables used by PowerBuilder for clerical staff (password protected)

- Readonly Role

  Select any table in the database used by PowerBuilder for SEs and individuals other than clerical staff.

- Voice Role

  Select, update, insert, or delete voice tables (password protected).

- POS Role

  Select, update, insert, or delete point of sale tables (password protected).

- EVS Role

  Select, update, insert, or delete eligibility verification tables (password protected).

- MARS

  Uses PowerBuilder role.

- SURS

Uses PowerBuilder role.

- Ad-Hoc

  Select adhoc tables in database, able to create temp tables. For specified adhoc users this is the default access.

- Connect internal

  Ability to do anything with the database. This is only allowed by DBA IDs.

DBA Tools

- SVRMGR

  This is an Oracle utility that provides the ability to access the database via menu options as well as administer and monitor the database. Administration and monitoring of the database is restricted to DBA IDs. Other options are based on the IDs ability to read and update tables. Refer to the section on roles for additional information.

- Change Management

  This is a software product that provides versioning of database changes. Unix group and file permissions, as well as database roles control access. Only DBA IDs have access to execute these jobs.

- SQLLOADER

  This is an Oracle utility that allows the ability to load data from flat files into an Oracle database. This is restricted to DBA and cycle IDs.

- Export/Import

  Oracle utilities that allow database data to be copied to flat files and then to copy the flat files back into the database. Access to export is restricted to IDs able to select or read from the desired tables. Access to import is restricted to DBA IDs and selected SE IDs.

- DBUNLOAD

  This is a utility that allows the database data to be copied to flat files in SQLLOADER format. Access is restricted to IDs, able to select and read from the database.

Database Installation Access

- DBA Access

In order to create, startup, shutdown, and perform the various maintenance tasks on a database requires DBA authority. Refer to the section on roles for additional information.

Developer Access Security

PowerBuilder

- Code Changes

  Code changes can only be moved into an executable, such as model office, user acceptance, or production directory, by an authorized ID. Refer to the section on version control for additional information.

Database Changes

Refer to the DBMS section for information about database changes.

All Other Program Codes

- Code Changes

  Code changes can only be moved into an executable, such as model office, user acceptance, or production directory, by an authorized ID. Refer to the section on version control for additional information.

- Database Changes

  All database access is by roles. Refer to the DBMS section for additional information.

Application Error Handling

Within LBMS coded Cobol, oracle errors are handled by functions the case tool automatically generates. Nonsql errors are handled by a linked *C module*.

Scheduling System

The scheduling system uses Computer Associates Autosys. Autosys is an automated job control system for scheduling, monitoring, and reporting. Autosys centralizes and automates the scheduling and management of jobs in a distributed UNIX environment. Autosys simplifies the managing and monitoring of thousands of jobs by providing centralized control of enterprise-wide networks and by allowing related tasks to be grouped into a single job stream. Autosys also provides job-scheduling

flexibility by basing start conditions on time and day, file arrival, and job dependencies such as success, failure, or process exit code.

Change Control

Application Objects

Versioning of code is provided by an EDS-written utility within the Unix environment, and Endeavor for the PowerBuilder PBL files.

LBMS generated Cobol code is created on a DOS machine and then transferred to the Unix environment. To be move the code into the customer directories the SE must version it using the VSC utility. This is the only way code can be moved into the customer directories. C code is also promoted within the Unix environment by the VSC utility.

PowerBuilder code is created on DOS platforms and then outside of PowerBuilder, within Endeavor, the code is promoted and versioned at the PBL level.

Database Objects

The following are database requirements:

1. Automate the DBMS DDL changes that must be applied to distributed databases. Any table being changed must have all characteristics preserved, including data, except for the items being changed, for example save grants, locations, and pctfree.
2. Keep distributed versions of tables in synch, such as node.database.owner.table.version.
3. Items to control:
   - Tables (tablespace, storage, pctfree, pctused, colum defaults)
   - Indices (tablespace, storage, pctfree, cluster)
   - Table constraints
   - Column constraints
   - Synonyms
   - Grants
4. Provide for a pre-processing program and post-processing program to be run prior to and after the database update portion runs. This is how views, grants, and data type change conversions are handled.
5. Allow creation of any version of DDL.
6. Allow a database to be efficiently upgraded by more than one version at a time.
7. Allow for disk and tape unloading of tables.
8. Allow parallel processing of DDL across nodes and on same nodes.

9. Dynamically generate copy-out and copy-in statements based on current catalog information.
10. The following items should be database dependent:
    - Tablespace
    - Storage
    - Pctfree
    - Pctused
    - Cluster
    - Grants
    - Table owner
    - Default grant for database
    - Default tablespace for database
    - Default unload areas for database
11. Develop a PowerBuilder GUI interface for managing database dependent items.
12. The following items are handled as a manual process updateable with the PowerBuilder application:
    - Set holds on column changes
    - Table, index, column name changes
    - Table locations
    - Index locations
13. Develop a copy-out and copy-in utility.

Section 4: Tables

Physical Tables and Database Design

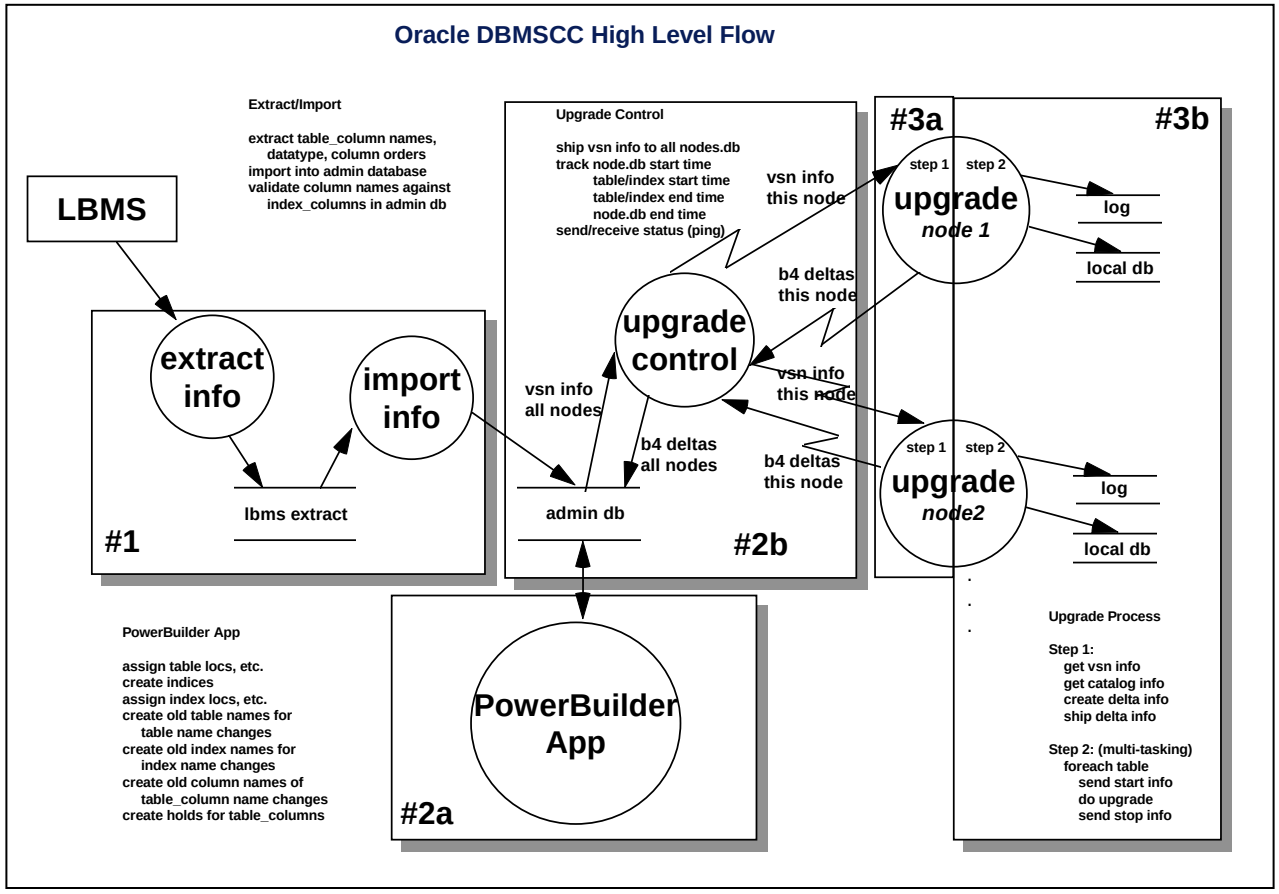

Figure 4.1 – Oracle High Level Flow

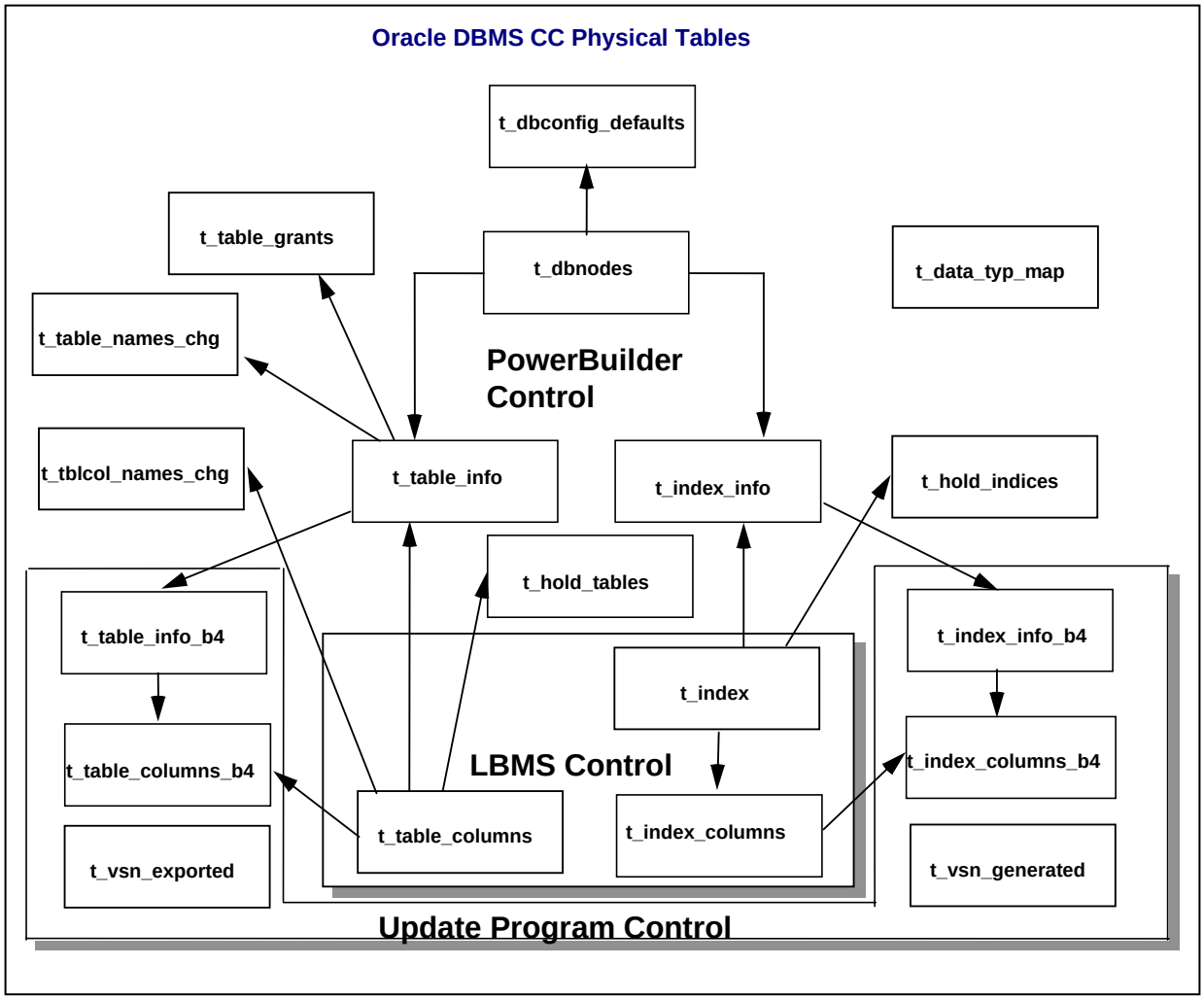

Figure 4.2 – Oracle Physical Tables

Physical Tables

Scripts located in the dba PRODDIR to make the admin tables and indices. The scripts are named as follows:

- ora_admin_tbl.sh – DDL for all tables
- ora_admin_idx.sh – DDL for all admin indices

Make sure any changes to the tables are updated in the scripts. Refer to the following scripts for the physical table layouts:

- t_data_typ_map

This table is a cross-reference of data types to resolve the CASE tool data type into the DBMS specific data type. The ANSI data type and a description is also tracked.

- t_dbconfig_dflts

  These are default grants and tablespace locations for each database to be used.

- t_dbconfig_unload

  These are the device types and names of areas to be used to unload tables during change management for each database.

- t_dbnodes

  Tracks all nodes in network along with the database names and database owners, along with the current version number and date and time stamp version applied to physical location.

- t_hold_tables

  This is a hold flag that can be set on a table column so it is ignored for a specific dbnode. This is specific to a version and must be applied through the online application if further holds are desired. The hold is resolved at runtime in the step one of the update. All prior holds are applied in subsequent versions unless another hold row is added.

- t_index

  Names of indices and table index are built on, plus uniqueness or nonuniqueness designations. Note index name must exist in table, t_index_info, table name must exist in t_table_info, and column name must exist in t_table_columns.

- t_index_columns

  Name and order of columns for indices. Note index name must exist in table t_index. t_index_info column name must exist in t_table_columns.

- t_index_columns_b4

  Before image of names and orders of columns for indices for those items that have changed from one version to another. This is for reporting purposes and exists for each dbnode.

t_index_info

Information about physical indices that includes all nodes/databases the table exists in along with the physical characteristics that apply to each index.

- t_index_info_b4

Before image of information pertaining to physical indices for items that have changed from one version to another. This is for reporting purposes and exists for each dbnode.

- t_table_columns

  Names and orders of columns for tables. Note table name must exist in table t_table_info. This information comes from the LBMS extract. For new tables, a row is inserted into t_table_info as part of the import process.

- t_table_columns_b4

  Before images of names and orders of columns for tables of items that have changed from one version to another. This is for reporting purposes and exists for each dbnode.

- t_table_info

  Information about physical tables that includes all nodes/databases where the table exists along with the physical characteristics that apply to each table.

- t_table_info_b4

  Before image of information about physical tables for items that have changed from one version to another. This is for reporting purposes and exists for each dbnode.

- t_table_names_chg

  This table holds the old table name for tables undergoing a name change. This is a manual process updated through the online application. It is only necessary if data is to be saved in the table with a name change. Otherwise, table name changes appear as a *delete* and an *add*.

- t_tblcol_names_chg

  This table holds the old table and column names for columns undergoing a name change. This is a manual process updated through the online application. It is only necessary if data is to be saved in the column with a name change. Otherwise, table name changes appear as a *delete* and an *add*.

- t_vsn_exported

  This table tracks the latest version exported from the CASE tool. Until another version is generated, any export is considered the last generated version +1. If data is exported more than once between generations, subsequent exports overlay the prior export.

- t_vsn_generated

  This table tracks the versions actually generated. A version is generated the first time it is requested for an update. This freezes the version definition.

Section 5: Back-up Recovery

Overview

The UNIX system backups are automatically scheduled to run each night. The system is backed up to 8mm Advanced Intelligent Tape (AIT-1). All 8mm tapes are contained in two automated 120 tape libraries with six Sony AIT drives in each. A full system backup is run on Sunday. Each successive day an incemental backup is run. The incremental backup will backup any file that has changed since the Sunday backup. Each day the Operations staff removes the completed backup tapes. The tapes are stored off-site at the DRA facility. The tapes remain off-site for one month before being returned and reused. There is a second full backup run on Sunday, these tapes remain on-site to be used to restore data.

The Test and Model environment databases are backed up utilizing Oracle's Export/Import technology every night Monday through Friday. The backup files are written to disk and backed up each night to tape by OS level filesystem backups. The previous three nightly Exports are kept on disk to allow for restores, if necessary. Every fourth day the oldest Export is removed from the system.

The Production database environment is backed up utilizing a filesystem backup methodology on a schedule as shown in the spreadsheet below. All Production databases are running in an Archive Log mode, which allows for Point-in-Time recovery utilizing the archived redo logs kept on disk and copied to tape throughout the day and night. The filesystem backup methodology is utilized for backup expediency due to the very large size of the databases. Export technology is very efficient, but the Import would be very time consuming if restores were required. On the other hand filesystem backups allow for very quick restore times based on the hardware technology utilized in the *AIM* solution. Copies of the database backup tapes are kept both onsite and at a offsite secure tape storage facility.

Table 5.1 -

Tape	Machine	Juke Box	Slot Number	Description	Replace With
Mon_inaimp1a_1	dsibsun2_fddi	jb1	2	Monday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Mon_inaimp1b_1	dsibsun2_fddi	jb1	3	Monday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Mon_inaimp1c_1	dsibsun2_fddi	jb1	4	Monday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Mon_inaimp1d_1	dsibsun2_fddi	jb1	5	Monday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Tue_inaimp1a_1	dsibsun2_fddi	jb1	6	Tuesday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Tue_inaimp1b_1	dsibsun2_fddi	jb1	7	Tuesday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Tue_inaimp1c_1	dsibsun2_fddi	jb1	8	Tuesday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Tue_inaimp1d_1	dsibsun2_fddi	jb1	9	Tuesday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Wed_inaimp1a_1	dsibsun2_fddi	jb1	10	Wednesday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Wed_inaimp1b_1	dsibsun2_fddi	jb1	11	Wednesday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Wed_inaimp1c_1	dsibsun2_fddi	jb1	12	Wednesday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Wed_inaimp1d_1	dsibsun2_fddi	jb1	13	Wednesday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Thu_inaimp1a_1	dsibsun2_fddi	jb1	14	Thursday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Thu_inaimp1b_1	dsibsun2_fddi	jb1	15	Thursday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Thu_inaimp1c_1	dsibsun2_fddi	jb1	16	Thursday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Thu_inaimp1d_1	dsibsun2_fddi	jb1	17	Thursday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Fri_inaimp1a_1	dsibsun2_fddi	jb1	18	Friday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Fri_inaimp1b_1	dsibsun2_fddi	jb1	19	Friday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Fri_inaimp1c_1	dsibsun2_fddi	jb1	20	Friday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
Fri_inaimp1d_1	dsibsun2_fddi	jb1	21	Friday On-Line Database Backup *UP* (inaimp1)	Rotation Tapes
DRA_inaimp1a_1	dsibsun2_fddi	jb1	22	DRA On-Line Database Backup *UP* (inaimp1) ** SEND TO DRA SITE **	DRA Recycle Tapes or New Tapes
DRA_inaimp1b_1	dsibsun2_fddi	jb1	23	DRA On-Line Database Backup *UP* (inaimp1) ** SEND TO DRA SITE **	DRA Recycle Tapes or New Tapes

Table 5.1 -

Tape	Machine	Juke Box	Slot Number	Description	Replace With
DRA_inaimp1c_1	dsibsun2_fddi	jb1	24	DRA On-Line Database Backup *UP* (inaimp1) ** SEND TO DRA SITE **	DRA Recycle Tapes or New Tapes
DRA_inaimp1d_1	dsibsun2_fddi	jb1	25	DRA On-Line Database Backup *UP* (inaimp1) ** SEND TO DRA SITE **	DRA Recycle Tapes or New Tapes
DumpSun_inceap1a_1	dsibsun2_fddi	jb1	26	Sunday Claim Engine 1 Dump Disk Location Backup *UP* (inceap1)	Rotation Tapes
DumpMon_inceap1a_1	dsibsun2_fddi	jb1	27	Monday Claim Engine 1 Dump Disk Location Backup *UP* (inceap1)	Rotation Tapes
DumpTue_inceap1a_1	dsibsun2_fddi	jb1	28	Tuesday Claim Engine 1 Dump Disk Location Backup *UP* (inceap1)	Rotation Tapes
DumpWed_inceap1a_1	dsibsun2_fddi	jb1	29	Wednesday Claim Engine 1 Dump Disk Location Backup *UP* (inceap1)	Rotation Tapes
DumpThu_inceap1a_1	dsibsun2_fddi	jb1	30	Thursday Claim Engine 1 Dump Disk Location Backup *UP* (inceap1)	Rotation Tapes
DumpFri_inceap1a_1	dsibsun2_fddi	jb1	31	Friday Claim Engine 1 Dump Disk Location Backup *UP* (inceap1)	Rotation Tapes
DumpDRA_inceap1a_1	dsibsun2_fddi	jb1	32	DRA Claim Engine 1 Dump Disk Location Backup *UP* (inceap1) ** SEND TO DRA SITE **	DRA Recycle Tapes or New Tapes
DRA_injobp1a_1	dsibsun2_fddi	jb1	33	DRA Autosys Database Backup *UP* (injobp1) ** SEND TO DRA SITE **	DRA Recycle Tapes or New Tapes
Mon_injobp1a_1	dsibsun2_fddi	jb1	34	Monday Autosys Database Backup *UP* (injobp1)	Rotation Tapes
Tue_injobp1a_1	dsibsun2_fddi	jb1	35	Tuesday Autosys Database Backup *UP* (injobp1)	Rotation Tapes
Wed_injobp1a_1	dsibsun2_fddi	jb1	36	Wednesday Autosys Database Backup *UP* (injobp1)	Rotation Tapes
Thu_injobp1a_1	dsibsun2_fddi	jb1	37	Thursday Autosys Database Backup *UP* (injobp1)	Rotation Tapes
Fri_injobp1a_1	dsibsun2_fddi	jb1	38	Friday Autosys Database Backup *UP* (injobp1)	Rotation Tapes
Sat_injobp1a_1	dsibsun2_fddi	jb1	39	Saturday Autosys Database Backup *UP* (injobp1)	Rotation Tapes

Table 5.2 -

Mon	Mon/21:30pm	dbap_bu_Mon_inhisp1	Mon_inhisp1a_1	dsibsun3_fddi	jb1	2	Read/Write Partiton Backup *UP* (inhisp1)	Rotation Tapes
Thu	Wed/21:30pm	dbap_bu_dra_inhisp1	DRA_inhisp1a_1	dsibsun3_fddi	jb1	3	Read/Write Partiton Backup *UP* (inhisp1) ** SEND TO DRA SITE **	DRA Recycle Tapes or New Tapes
Mon	Tue/23:00pm	dbap_bu_Tue_inmarp1	Tue_inmarp1a_1	dsibsun3_fddi	jb1	4	Tuesday MAR Database Backup *UP* (inmarp1)	Rotation Tapes
Mon	Tue/23:00pm	""	Tue_inmarp1b_1	dsibsun3_fddi	jb1	5	Tuesday MAR Database Backup *UP* (inmarp1)	Rotation Tapes
Mon	Tue/23:00pm	""	Tue_inmarp1c_1	dsibsun3_fddi	jb1	6	Tuesday MAR Database Backup *UP* (inmarp1)	Rotation Tapes
Mon	Tue/23:00pm	""	Tue_inmarp1d_1	dsibsun3_fddi	jb1	7	Tuesday MAR Database Backup *UP* (inmarp1)	Rotation Tapes
Mon	Tue/23:00pm	""	Tue_inmarp1e_1	dsibsun3_fddi	jb1	8	Tuesday MAR Database Backup *UP* (inmarp1) ** RESERVED FOR FUTURE USE **	Rotation Tapes
Mon	Thu?23:00pm	dbap_bu_Thu_indssp1	Thu_indssp1a_1	dsibsun3_fddi	jb1	9	Thursday DSS Database Backup *DOWN* (indssp1)	Rotation Tapes
Mon	Thu?23:00pm	""	Thu_indssp1b_1	dsibsun3_fddi	jb1	10	Thursday DSS Database Backup *DOWN* (indssp1)	Rotation Tapes
Mon	Thu?23:00pm	""	Thu_indssp1c_1	dsibsun3_fddi	jb1	11	Thursday DSS Database Backup *DOWN* (indssp1)	Rotation Tapes
Mon	Thu?23:00pm	""	Thu_indssp1d_1	dsibsun3_fddi	jb1	12	Thursday DSS Database Backup *DOWN* (indssp1)	Rotation Tapes
Mon	Thu?23:00pm	""	Thu_indssp1e_1	dsibsun3_fddi	jb1	13	Thursday DSS Database Backup *DOWN* (indssp1)	Rotation Tapes
Mon	Thu?23:00pm	""	Thu_indssp1f_1	dsibsun3_fddi	jb1	14	Thursday DSS Database Backup *DOWN* (indssp1)	Rotation Tapes

Table 5.2 -

Sat	Fri/23:00pm	dbap_bu_dra_inmarp1	DRA_inmarp1a_1	dsibsun3_fddi	jb1	21	DRA MAR Database Backup *UP* (inmarp1)	DRA Recycle Tapes or New Tapes
Sat	Fri/23:00pm	""	DRA_inmarp1b_1	dsibsun3_fddi	jb1	22	DRA MAR Database Backup *UP* (inmarp1)	DRA Recycle Tapes or New Tapes
Sat	Fri/23:00pm	""	DRA_inmarp1c_1	dsibsun3_fddi	jb1	23	DRA MAR Database Backup *UP* (inmarp1)	DRA Recycle Tapes or New Tapes
Sat	Fri/23:00pm	""	DRA_inmarp1d_1	dsibsun3_fddi	jb1	24	DRA MAR Database Backup *UP* (inmarp1)	DRA Recycle Tapes or New Tapes
Sat	Fri/23:00pm	""	DRA_inmarp1e_1	dsibsun3_fddi	jb1	25	DRA MAR Database Backup *UP* (inmarp1)	DRA Recycle Tapes or New Tapes
Sat	Fri/23:00pm	""	DRA_inmarp1f_1	dsibsun3_fddi	jb1	25	DRA MAR Database Backup *UP* (inmarp1) ** RESERVED FOR FUTURE USE **	DRA Recycle Tapes or New Tapes
Mon	On-Req/Sat/08:30am	dbap_bu_RED_inhisp1	RED_inhisp1a_1	dsibsun3_fddi	jb1	27	Read Only Partition Backup *UP* (inhisp1)	Rotation Tapes
Mon	On-Req/Sat/08:30am	""	RED_inhisp1b_1	dsibsun3_fddi	jb1	28	Read Only Partition Backup *UP* (inhisp1)	Rotation Tapes
Mon	On-Req/Sat/08:30am	""	RED_inhisp1c_1	dsibsun3_fddi	jb1	29	Read Only Partition Backup *UP* (inhisp1)	Rotation Tapes
Mon	On-Req/Sat/08:30am	""	RED_inhisp1d_1	dsibsun3_fddi	jb1	30	Read Only Partition Backup *UP* (inhisp1)	Rotation Tapes
Tue	Mon/23:00pm	dbap_bu_dra_indssp1	DRA_indssp1a_1	dsibsun3_fddi	jb1	15	DRA DSS Database Backup *DOWN* (indssp1) Remove Mon Tape, Send offsite	DRA Recycle Tapes or New Tapes

Table 5.2 -

Tue	Mon/23:00pm	""	DRA_indssp1b_1	dsibsun3_fddi	jb1	16	DRA DSS Database Backup *DOWN* (indssp1) Remove Mon Tape, Send offsite	DRA Recycle Tapes or New Tapes
Tue	Mon/23:00pm	""	DRA_indssp1c_1	dsibsun3_fddi	jb1	17	DRA DSS Database Backup *DOWN* (indssp1) Remove Mon Tape, Send offsite	DRA Recycle Tapes or New Tapes
Tue	Mon/23:00pm	""	DRA_indssp1d_1	dsibsun3_fddi	jb1	18	DRA DSS Database Backup *DOWN* (indssp1) Remove Mon Tape, Send offsite	DRA Recycle Tapes or New Tapes
Tue	Mon/23:00pm	""	DRA_indssp1e_1	dsibsun3_fddi	jb1	19	DRA DSS Database Backup *DOWN* (indssp1) Remove Mon Tape, Send offsite	DRA Recycle Tapes or New Tapes
Tue	Mon/23:00pm	""	DRA_indssp1f_1	dsibsun3_fddi	jb1	20	DRA DSS Database Backup *DOWN* (indssp1) Remove Mon Tape, Send offsite	DRA Recycle Tapes or New Tapes

Section 6: Database

Database Naming Standards

ssttten where:

ss is the State code
in for indiana

ttt is the type of database
cea, ceb for claims (a/b for switch)
fin for financial
aim for online (reference, provider, and recip)
q*xyy* where x is the quarter and yy is the year for history

e is the environment code
p = production
m = model office
a = user acceptance
r = regression testing
t = test / development

n sequence number of the database

The term *logical database* refers to a collection of databases in a given environment. The *production database* is a collection of database types such as claims databases, reference databases, or history databases. Since each type can occur in more than one place, a sequence number is added to all database names. The claims database and the job scheduling database are replicated on another node for fail-over purposes. The reference database is a single database that can only be updated online. Data in the reference database is extracted daily and updated into the claims database. The history database is partitioned chronologically. Quarterly partitioning is used but it is necessary to ensure all programs that update or query these databases allow for different chronological partitioning such as reading a parm record that tells which database a date is located in.

Table 6.1 – Platform Architecture

Host	dsibsunA	Dsibsun0	dsibsun1	dsibsun2	dsibsun3
Test Database		Inaimt1			
		Inhist1			
		Inmart1			
		Indsst1			
Model Database		Inaimm1			
		inceam1			
		inhism1			
		inmarm1			

Table 6.1 – Platform Architecture

Host	dsibsunA	Dsibsun0	dsibsun1	dsibsun2	dsibsun3
		indssm1			
Production Database		inadmp1			
			inceap1		
			injobp1		
				inaimp1	
					inhisp1
					inmarp1
					indssp1
ACC	inaima1				
	inceaa1				
	inhisa1				
	inmara1				

Since it is assumed financial updates history in the current year, this runs on dsibsun3. Online runs on dsibsun2 since online and financial do not run at the same time. Model Office runs on dsibsun0 where the oldest history records reside. The claims engine runs on dsibsun1 with fail-over capability on dsibsun2.

Physical Database Design Changes

In order to implement a distributed environment, control tables must be added to every host to point to the database names for partitioning.

- t_dbnodes
  - sak_dbnode
  - node name
  - database name
  - logical database name
- t_hist_locs
  - sak_dbnode
  - begin date
  - end data
- t_ref_locs
  - sak_dbnode
  - master_slave_ind
- t_ce_locs
  - sak_dbnode
  - master_slave_ind

Design Standards

Table to Tablespace mapping

Index Layout Tables and indices will reside in different tablespaces to insure maximum performance.

Production Table Size Estimates/Assumptions

Glossary

1115(a) Section of the Social Security Act that allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, system-wide changes are possible under this provision. Waivers must be approved by CMS. See also *Health Care Financing Administration, Waiver*.

11971 State form 11971; see *8A*.

1261A Division of Family and Children State Form 1261A, *Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*

1500 This is a claim form used by participating Indiana Health Coverage Programs (IHCP*)* providers to bill medical and medically related services. See also *CMS-1500*.

1902(a)(1) Section of the Social Security Act that requires state Medicaid programs be in effect "in all political subdivisions of the state". See also *Statewideness.*

1902(a)(10) Section of the Social Security Act that requires state Medicaid programs provide services to people that are comparable in amount, duration and scope. See also *Comparability; Sections 1915(a), (b), and (c); Waiver*.

1902(a)(23) Section of the Social Security Act that requires state Medicaid programs ensure clients have the freedom to choose any qualified provider to deliver a covered service. See also *Freedom of Choice, Section 1915(b), Waiver.*

1902(r)(2) Section of the Social Security Act that allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income (SSI) eligibility for determining Medicaid eligibility.

1903(m) Section of the Social Security Act that allows state Medicaid programs to develop risk contracts with health maintenance organizations or comparable entities. See also *Risk Contracts*.

1915(a) Section of the Social Security Act that states requirements for Medicaid.

1915(b) Section of the Social Security Act that allows states to waive Freedom of Choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager. Waivers must be approved by CMS.

1915(c) Section of the Social Security Act that allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an ICF-MR, nursing facility or Institution for Mental Disease, or inpatient hospital. Waivers must be approved by CMS. See also *CLASS, HCS, MDCP, CMS, NF, Waiver.*

1915(c)(7)(b)	Section of the Social Security Act that allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by CMS. See also *CMS, HCS-O, Waiver*.
1929	Section of the Social Security Act that allows states to provide a broad range of home and community care to functionally disabled individuals as an optional state plan benefit. The option can serve only people over 65. In Indiana, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also *Home and Community Care.*
450A	Social Evaluation for Long Term Care Admission
450B	Certification by Physician for Long Term Care Services.
590 Program	A State health coverage program for institutionalized persons under the jurisdiction of the Division of Mental Health and Department of Health.
7748	State Form 7748, Medicaid Financial Report
8A	*DPW Form 8A (State Form 11971), Notice to Provider of Member Deductible*. Used to relay member spenddown information to providers when the date of service is the same as the spenddown met date.
AA	Anesthesia Assistant.
AAA	Area Agency on Aging. This agency is a significant element in Home and Community-Based Services Waiver Programs.
AAC	Alternative or Augmentative Communication device.
AAP	American Academy of Pediatrics.
AAS	Atomic absorption spectrophotometer.
ABA	American Banking Association.
ABG	Arterial blood gas.
access	Term used to describe the action of entering and utilizing a computer application.
accommodation charge	A charge used only in institutional claims for bed, board, and nursing care.
accretion	An addition to a file or list. For example: the monthly additions to the Medicare Buy-In List.
ACOG	American College of Obstetricians and Gynecologists.
ACS	Affiliated Computer Services. State Healthcare PBM. Pharmacy Benefits Manager, Drug Rebate Services.

ACSW	Academy of Certified Social Workers.
ADA	American Dental Association.
ADAP	AIDS Drug Assistance Program.
ADC	Adult day care.
adjudicate (claim, credit, adjustment)	To process a claim to pay or deny.
adjustment	(1) A transaction that adjusts and reprocesses a previously processed claim; (2) the contractor adjusts a provider's account by debiting underpayments or crediting overpayments on claims.
adjustment recoupments	Recoupments set up by the adjustments staff on recoup and reprocess transactions. A record of these recoupments is maintained by the Cash Control System until zero balanced.
ADL	Activities of daily living.
Advance Planning Document (APD)	A planning guide the federal government requires when a state is requesting 90 percent funding for the design, development, and implementation of an MMIS.
AFDC	Aid to Families with Dependent Children is replaced by Temporary Assistance to Needy Families (TANF).
AG	Attorney General.
Aged and Medicare-Related Coverage Group	Needy individuals who have been designated by Department of Human Services (DHS) as medical assistance members, who are 65 years old or older, or members under any other category who are entitled to benefits under Medicare.
AHF	Antihemophiliac factor.
aid category	A designation within the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Aid to Families with Dependent Children (AFDC)	Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act. Replaced by Temporary Assistance to Needy Families (TANF).
Aid to the Blind (AB)	A classification or category of members eligible for benefits under the IHCP.
AIDS	Acquired Immune Deficiency Syndrome.
AIM	Advanced Information Management.
ALJ	Administrative Law Judge.
allowed amount	Either the amount billed by a provider for a medical service, the Department's established fee, or the reasonable charge, whichever is the lesser figure.
alpha	A field of only alphabetical letters.

alphanumeric	A field of numbers and letters.
ALS	Advanced life support.
ambulance service supplier	A person, firm or institution approved for and participating in Medicare as an air, ground, or host ambulance service supplier or provider.
amount, duration, and scope	How an IHCP benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.
ancillary charge	A charge, used only in institutional claims, for any item except accommodation fees. Examples include drug, laboratory and x-ray charges.
APS	Adult Protective Services.
ARC	Association of Retarded Citizens.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
Area Agency on Aging	Also known as AAA. This agency is a significant element in Home and Community-Based Services Waiver Programs.
Area Prevailing Charge	Under Medicare Part B, the charge level that on the basis of statistical data would cover the customary charges made for similar services in the same locality.
ASC	Ambulatory Surgery Center.
AT	Action Team.
Attending Physician	The physician providing specialized or general medical care to a member.
Auditing Contractor	The entity under contract with the Office of Medicaid Policy and Planning (OMPP) to conduct audits of long-term-care facilities or other functions and activities as designated by OMPP.
auto assignment	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
Automated Voice Response (AVR)	Computerized voice response system that helps providers obtain pertinent information concerning member eligibility, benefit limitation, check information, and prior authorization (PA) for those participating in the IHCP.
Average Wholesale Price; used in reference to drug pricing.	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
AVR	Automated voice-response system used by providers to verify member eligibility by phone.
AWP	Average wholesale price used for drug pricing.

banner page	Brief messages sent to providers with the weekly remittance advices (RAs).
behavorial health care	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
BENDEX	Beneficiary Data Exchange. A file containing data from CMS about persons receiving Medicaid benefits from the Social Security Administration.
Beneficiary	One who benefits from program such as the IHCP. Most commonly used to refer to people enrolled in the Medicare program.
benefit	A schedule of health care service coverage that an eligible participant in the IHCP receives for the treatment of illness, injury, or other conditions allowed by the State.
benefit level	Limit or degree of services a person is entitled to receive based on his or her contract with a health plan or insurer.
bidder	Any corporation, company, organization, or individual that responds to a Request for Proposal (RFP).
bill	A statement of charges for medical services, the submitted claim document, or electronic record; which may contain one or more services performed.
billed amount	The amount of money requested for payment by a provider for a particular service rendered.
billing provider	The party responsible for submitting to the department the bills for services rendered to an IHCP member.
billing service	An entity under contract with a provider that prepares billings on behalf of the provider for submission to payers.
block	Specific area on a claim or worksheet containing claim information.
BLS	Basic Life Support.
Blue Book	The *American Druggist Blue Book*, used as a reference in pricing drug products.
Boren Amendment	An amendment to *OBRA 80 (P.O. 96-499)*, which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities (NF) and intermediate care facility for the mentally retarded (ICF/MR) under the IHCP. The amendment substituted language that required states to develop payment rates that were "reasonable and adequate" to meet the costs of "efficiently and economically operated" providers. Boren was intended to give states new flexibility but it has increased successful lawsuits by providers and thus has contributed to the rising cost of Medicaid-funded institutional care.
BQAMIS	Bureau of Quality Assurance Management Information System.
BSN	Bachelor of Science in Nursing.
BSW	Bachelor of Social Work.
budgeted amount	The planned expenditures for a given time period.

bulletins	Informational directives sent to providers of IHCP services containing information on regulations, billing procedures, benefits, processing, or changes in existing benefits and procedures.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP members, enrolling them in Medicare Part A or Part B or both programs.
C&T	Certification and Transmittal; a document from the Indiana State Department of Health (ISDH).
C519	Authorization for Member Liability Deviation, generated by the Medicaid recipient's county caseworker. Applies only to nursing residents.
cap	A finite limit on the number of certain services for which the department will pay for a given member per calendar year.
capitation	A prospective payment method that pays the provider of service a uniform amount for each person served usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.
CARF	Commission on Accreditation of Rehabilitation Facilities
carrier	An organization processing Medicare claims on behalf of the federal government.
carve out	A decision to purchase separately a service that is typically a part of an indemnity (a HMO plan). (For example, the behavioral health benefit might be carved out to a specialized vendor to supply these services as stand-alone.)
case management	A process whereby covered persons with specific health care needs are identified and a plan which efficiently uses health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.
case manager	An experienced professional (for example, nurse, doctor or social worker) who works with clients, providers, and insurers to coordinate all necessary services to provide the client with a plan of medically necessary and appropriate health care.
Cash Control Number (CCN)	Financial control number assigned to uniquely identify all refunds or repayments prior to their setup within the cash control system. The batch range within the CCN identifies the type of refund or repayment.
cash control system	Process whereby the case unit creates and maintains the records for accounts receivable, recoupments, and payouts.
categorically needy	All individuals receiving financial assistance under the State's approved plan under Titles I, IV-A, X, XIV, and XVI of the Social Security Act or who are in need under the State's standards for financial eligibility in such plan.
category code	A designation indicating the type of benefits for which an IHCP member is eligible.

category of service	A designation of the nature of the service rendered (for example, hospital outpatient, pharmacy, physician).
CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider that submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CCSW	Certified Clinical Social Worker.
CDC	Centers for Disease Control.
CDFC	County Division of Family and Children.
CDPW	County Department of Public Welfare, which is changed to the County Offices of the Division of Family and Children.
CDT	Current Dental Terminology.
CEO	Chief Executive Officer.
certification	A review of CMS of an operational MMIS in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system; also, the ensuing certification resulting from a favorable review.
certification code	A code PCCM PMPs use to authorize PCCM members to seek services from speciality providers.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CHAMPUS	Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS); health-care plan for active duty family members, military retirees and family members of military retirees, now known as TRICARE.
charge center	A provider accounting unit within an institution used to accumulate specific cost data related to medical and health services rendered (for example, laboratory tests, emergency room service, and so forth.).
Children's Special Health Care Services (CSHCS)	State program that provides assistance for children with chronic health problems who are not necessarily eligible for Medicaid.
CHIP	Children's Health Insurance Program.
CI	Continual improvement.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: CMS-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.

Claim Correction Form (CCF)	Automatically generated for certain claim errors and sent to providers with the weekly RA. Allows providers the opportunity to correct specified errors detected on the claim during the processing cycle.
claim transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: (1) Claims (2) Credits (3) Adjustments.
claim type	Three-digit numeric code that refers to the different billing forms used by the program.
claims history file	Computer file of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
claims processing agency	Agency that performs the claims processing function for IHCP claims. The agency may be a department of the single state agency responsible for Title XIX or a contractor of the agency, such as a fiscal agent.
clean claim	Claim that can be processed without obtaining additional information from the provider or from a third party.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
client	A person enrolled in the IHCP and thus eligible to receive services funded through the IHCP.
Cm	Centimeter.
CMHC	Community Mental Health Center.
CMI	Case Mix Index.
CMN	Certificate of Medical Necessity.
CMS	Centers for Medicare and Medicaid Services.
CMS-1500	CMS-approved standardized claim form used to bill professional services. Formerly referred to as HCFA-1500.
COB	Coordination of benefits.
co-insurance	The portion of Medicare-determined allowed charge that a Medicare member is required to pay for a covered medical service after the deductible has been met. The co-insurance or a percentage amount is paid by IHCP if the member is eligible for Medicaid. See also *Cost Sharing*.
Commerce Clearing House Guide	A publication containing Medicaid and Medicare regulations.
Community Living Assistance and Support Services (CLASS)	A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to people with development disabilities other than mental retardation as an alternative to ICF MR VIII institutional care. Administered by Department of Human Services (DHS). See also *ICF MR, 1915(c), Waiver*.

Computer-Output Microfilm (COM)	The product of a device that converts computer data directly to formatted microfilm images bypassing the normal print of output on paper.
concurrent care	Multiple services rendered to the same patient during the same time period.
consent to sterilization	Form used by IHCP members certifying that they give "informed consent" for sterilization to be performed (it must be signed at least 30 days prior to sterilization).
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
Contractor	Offeror with whom the State successfully negotiated a contract pursuant to *IC 12-1-7-17*. **Auditing Contractor** – The entity under contract with the OMPP to conduct audits of long-term-care facilities or other functions and activities as designated by the OMPP. **Fiscal Agent Contractor** – The offeror(s) with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities. **Rate-Setting Contractor** – Entities under contract with the OMPP to perform rate-setting activities for hospitals and long-term-care facilities.
conversion factor	Number that when multiplied by a particular procedure code's relative value units would yield a substitute prevailing charge that could be used when an actual prevailing charge does not exist.
copayment or copay	A cost-sharing arrangement that requires a covered person to pay a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. See also *Cost Sharing*.
core contractor	The successful bidder on *Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services.*
COS	Category of Service.
cost settlement	Process by which claims payments to institutional providers are adjusted yearly to reflect actual costs incurred.

cost sharing	The generic term that includes co-payments, coinsurance, and deductibles. Co-payments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (for example, 20 percent) that an insured person must pay out-of-pocket. Deductibles are specified caps on out-of-pocket spending that an individual or a family must incur before insurance begins to make payments.
county office	County offices of Family and Children. Offices responsible for determining eligibility for Medicaid using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP members subject to the limitations of the *Indiana Administrative Code* (IAC).
CP	Clinical psychologist.
CPAS	Claims processing assessment system. An automated claims analysis tool used by the State for contractor quality control reviews.
CPM	Continuous Passive Motion.
CPS	Child Protective Services.
CPT	Current Procedural Terminology.
CPT Codes (Current Procedural Terminology)	Unique coding structure scheme of all medical procedures approved and published by the American Medical Association.
CPU	Central Processing Unit.
CQM	Continuous quality management.
credit	A claim transaction that has the effect of reversing a previously processed claim transaction.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
Crippled Children's Program	Title V of the Social Security Act allowing states to locate and provide health services to crippled children or children suffering from conditions leading to crippling. Former term for CSHCS.
CRLD	Computer report to laser disk.
CRNA	Certified Registered Nurse Anesthetist.
crossover claim	A claim for services, rendered to a patient eligible for benefits under both Medicaid and Medicare Programs, Titles XVIII and XIX, potentially liable for payment of qualified medical services. (Medicare benefits must be processed prior to IHCP benefits).

CRT Terminal (Cathode-Ray Tube Terminal)	A type of input/output device that may be programmed for file access capabilities, data entry capabilities or both.
CSHCS	Children's Special Health Care Services. A State-funded program providing assistance to children with chronic health problems. CSHCS members do not have to be IHCP-eligible. If they are also eligible for the IHCP, children can be enrolled in both programs.
CSR	Customer Service Request.
CSW	Certified Social Worker
customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP program, including State staff, members, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).
CVP	Central venous pressure.
D&E	Diagnostic and evaluation (in reference to services and providers).
DASS	Delivery and Support System.
data element	A specific unit of information having a unique meaning.
DC	Doctor of Chiropractic.
DD	Developmentally disabled or developmental disabilities.
DDARS	Division of Disability, Aging, and Rehabilitative Services.
DDE	Direct data entry.
DDS	Doctor of Dental Surgery.
deductible	Fixed amount that a Medicare member must pay for medical services before Medicare coverage begins. The deductible must be paid annually before Part B medical coverage begins; and it must be paid for each benefit period before Part A coverage begins.
DESI	Drug Efficacy Study and Implementation, drug determined to be less than effective (LTE); not covered by the IHCP.
designee	A duly authorized representative of a person holding a superior position.
detail	Information on a claim that denotes a specific procedure or category of certain services and the total charge billed for the procedure(s) involved. Also used to describe lines within a screen segment; for example, those listed to describe periods of eligibility.
development disability	Mental retardation of a related condition. A severe, chronic disability manifested during the developmental period that results in impaired intellectual functioning or deficiencies in essential skills. See also *Mental Retardation, Related Condition*.

DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through CMS.
DHS	Department of Human Services.
diagnosis	The classification of a disease or condition. (1) The art of distinguishing one disease from another. (2) Determination of the nature of a cause of a disease. (3) A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem. (4) A code for the above. See also *ICD-9-CM, DRG*.
digit	Any symbol expresses an idea or information, such as letters, numbers, and punctuation.
direct price	Price the pharmacist pays for a drug purchased from a drug manufacturer.
disallow	To determine that a billed service(s) is not covered by the IHCP and will not be paid.
disposition	Application of a cash refund to a previously finalized claim. Also used in processing claims to identify claim finalization—payment or denial.
DME	Durable medical equipment. Examples: wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DMH	Division of Mental Health.
DMHA	Division of Mental Health and Addictions.
DO	Doctor of Osteopathy.
DOB	Date of birth.
DOS	Date of service; the specific day services were rendered.
down	Term used to describe the inactivity of the computer due to power shortages or equipment problems. Entries on a terminal are not accepted during down time.
DPOC	Data Processing Oversight Commission. Indiana state agency that oversees agency compliance with all State data processing statutes, policies, and procedures.
DPW	Department of Public Welfare, the previous name of the Family and Social Services Administration
DPW Form 8A	See *8A*.
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
drug code	Code established to identify a particular drug covered by the IHCP.
Drug Efficacy Study and Implementation (DESI)	A drug determined to be less than effective (LTE) and not covered by the IHCP.

drug formulary	List of drugs covered by a State Medicaid Program, which includes the drug code, description, strength and manufacturer.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSM	Diagnostic and Statistical Manual of Mental Disorders; a revision series number is usually associated with the acronym.
DSS	Decision Support System. A data extraction tool used to evaluate IHCP data, trends, and so forth, for the purpose of making programmatic decisions.
dual eligible	A person enrolled in Medicare and Medicaid.
duplicate claim	A claim that is either totally or partially a duplicate of services previously paid.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
E/M	Evaluation and Management.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and personal computers for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECF	Extended care facility; most commonly, long-term care (LTC); or nursing home (NH), or nursing facility (NF).
ECM	Electronic claims management; overall management of claim transmittal via electronic media; related to ECS, EMC, ECC, and paperless claims.
ECS	Electronic claims submission. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.
EDI	Electronic data interchange.
EDP	Electronic data processing.
EDS	Electronic Data Systems Corporation, the IHCP claims processing and third party liability contractor.
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
EIP	Early Intervention Program
eligibility file	File containing individual records for all persons who are eligible or have been eligible for the IHCP.

eligible member Person certified by the State as eligible for medical assistance in accordance with the State Plan(s) under Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, or State law.

eligible providers Person, organization, or institution approved by the Single State Agency as eligible for participation in the IHCP.

EMC Electronic media claims. Claims submitted in electronic format rather than paper. See ***ECC, ECS***.

EMS Emergency medical services.

EOB Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.

EOMB Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to members. The EOMB details the payment or denial of claims submitted by providers for services provided to members. See also *MRN*.

EOP Explanation of payment, term previously used by the IHCP for the claim summary statement – currently know as a remittance advice (RA). Other insurers continue to use the term for claim statements to providers.

EPSDT Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for IHCP-eligible members younger than 21 years old offering free preventive health care services, such as: screenings, well-child visits, and immunizations. If medical problems are discovered, the member is referred for further treatment.

error code Code connected to a claim transaction indicating the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.

errors Claims that are suspended prior to adjudication. Several classifications of errors could exist; for example claims with data discrepancies or claims held up for investigation of possible third party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design. See also *Rejected Claim*.

ESRD End Stage Renal Disease.

EST Eastern Standard Time, which is also Indianapolis local time, is a constant in *the majority* of the state of Indiana. This means that from the last Sunday in April to the last Sunday in October Indianapolis is on the same time as the states observing Central Standard Time (CST), like Chicago. From the last Sunday in October to the last Sunday in April Indianapolis is on the same time as the states observing Eastern Standard Time (EST), like New York. This is because Indiana does not observe daylight savings time.

EVS Eligibility Verification System. A system used by providers to verify member eligibility using a point-of-sale device, on-line PC access, or an automated voice-response system.

exclusions Illnesses, injuries, or other conditions for which there are no benefits.

Exclusive Provider Organization (EPO)	Arrangement between a provider network and a health insurance carrier or self-insured employer that requires the beneficiary to use only designated providers or sacrifice reimbursement altogether. See also *Preferred Provider Organization.*
Explanation of benefits (EOB)	An explanation of claim denial or reduced payment included on the provider's RA.
Family Planning Service	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.
FAMIS	Family Assistance Management Information System.
FDB	First DataBank.
Fee-For-Service Reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide. See also *Indemnity Insurance*.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
FFS	Fee-for-service.
FID	Federal Investigation Database.
field audit	A provider's facilities, procedures, records and books are reviewed for conformance to IHCP standards. A field audit may be conducted regularly, routinely, or on a special basis to investigate suspected misutilization.
FIPS	Federal information processing standards.
Fiscal Agent Contractor	The offeror with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities.
fiscal month	Monthly time interval in a fiscal year.
Fiscal Year	The designated annual reporting period for an entity: State of Indiana – July 1 through June 30 Federal – October 1 through September 30
FISS	Fiscal intermediary shared system.
flat rate	Reimbursement methodology in which all providers delivering the same service are paid at the same rate. Also known as a Uniform Rate.

FMAP	Federal Medical Assistance Percentage. The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
Form 1261A	Division of Family and Children State Form 1261A, *Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility.*
FPL	Federal poverty level. Income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.
FQHC	Federally Qualified Health Center. A center receiving a grant under the Public Health Services Act or entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.
freedom of choice	A State must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.
front end	First process of claim cycle designed to create claim records, perform edits, and produce inventory reports.
front-end process	All claims system activity that occurs before auditing.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the IHCP.
FTE	Full time employee.
FUL	Federal upper limit, the pricing structure associated with maximum allowable cost (MAC) pricing.
GCN*SEQND	Generic code sequence number classification system.
generic drug	A chemically equivalent copy designed from a brand name whose patent has expired and is typically less expensive.
Gm	Gram.
GPCI	Geographic practice cost index.
GPCPD	Governor’s Planning Council for People with Disabilities.
GPI	Generic pricing indicator.

Group Model Health Maintenance Organization	A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
group practice	A medical practice in which several physicians render and bill for services under a single billing provider number.
hard copy claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as “paper” and “manual”.
HBP	Hospital-Based Physician. A physician who performs services in a hospital setting and has a financial arrangement to receive income from that hospital for the services performed.
HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged members to allow them to live in the community and avoid being placed in an institution.
HCE	Health Care Excel, Inc. The IHCP prior authorization, surveillance and utilization review and medical policy contractor
HCFA-1500	CMS-approved standardized claim form used to bill professional services. Now referred to as CMS-1500.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	Healthcare Common Procedure Coding System. A uniform health care procedural coding system approved for use by CMS. HCPCS includes all subsequent editions and revisions.
header	Identification and summary information at the head (top) of a claim form or report.
HealthWatch	Indiana’s preventive care program for IHCP members younger than 21 years old. Also known as EPSDT.
HEDIS	Health Plan Employer Data and Information Set. A core set of performance measures developed for employers to use in assessing health plans.
help	An online computer function designed to assist users when encountering difficulties entering a screen.
HHA	Home Health Agency. An agency or organization approved as a home health agency under Medicare and designated by ISDH as a Title XIX home health agency.

HHPD	Hoosier Healthwise for Persons with Disabilities and Chronic Diseases, formerly referred to as MCPD. HHPD is one of three delivery systems in the Hoosier Healthwise managed care program. In HHPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
HHS	Health and Human Services. U.S. Department of Health and Human Services. Umbrella agency for the Office of Family Assistance, the CMS, the Office of Refugee Resettlement (ORR), and other federal agencies serving health and human service needs.
HIC	Health insurance carrier number.
HIC #	Health Insurance Carrier Number. Identification number for those patients with Medicare coverage. The HIC# is usually the patient's Social Security number and an alphabetic suffix that denotes different types of benefits.
HIO	Health insuring organization.
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health insurance premium payments.
HIV	Human Immunodeficiency Virus
HMO	Health maintenance organization.
HMO	Health maintenance organization. Organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also *Sections 1903(m) and 1915 (b), PHP, PPO, Primary Care Case Management.*
HMS	Health Management Services.
Home and Community Care for the Functionally Disabled	An optional state plan benefit that allows states to provide HCBS to functionally disabled individuals (In Indiana, this optional benefit is used by ISDH to provide personal care services to people who have income in excess of SSI limitations but who would be financially qualified in an institution.) Also known as the "Frail Elderly" provision, although Indiana can serve people of any age under this provision. See also *Section 1919, Primary Home Care.*
Home and Community-Based Services-Omnibus Budget Reconciliation Act (HCS-OBRA)	A waiver of the Medicaid state plan granted under Section *1915(c)(7)(b)* of the Social Security Act that allows Indiana to provide community-based services to certain people with developmental disabilities placed in nursing facilities but requiring specialized service according to the PASARR process. See also *Section 1915(c)(7)(b), PASARR, Waiver.*
Home Health Care Services	Visits ordered by a physician authorized by DHS and provided to homebound members by licensed registered and practical nurses and nurses aids from authorized home health care agencies. These services include medical supplies, appliances, and DME suitable for use in the home.

Hoosier Healthwise	Hoosier Healthwise is an IHCP managed care program that consists of two components including Primary Care Case Management (PCCM) and risk-based managed care (RBMC).
HOPA	Hospital outpatient area.
HPB	Health Professions Bureau.
HPSA	Health professional shortage area.
HPSB	Health Professions Service Bureau.
HRI	Health-related items.
HRR	High risk register (in relation to audiological screening).
HSA	Home service agency.
HSPP	Health services provider in psychology.
IAC	*Indiana Administrative Code – Indiana rules.* State government agency administrative procedures.
IC	Indiana Code – Indiana laws.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF	Intermediate care facility. Institution providing health-related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing home, but who, because of their physical or mental condition, require services beyond the level of room and board.
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for IHCP-eligible, mentally retarded individuals.
ICHIA	Indiana Comprehensive Health Insurance Association, a health insuring organization for special situations.
ICLPPP	Indiana Childhood Lead Poisoning Prevention Program.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
ICU	Intensive care unit.
IDDARS	Indiana Division of Disability, Aging, and Rehabilitative Services.
IDEA	Individuals with Disabilities Education Act.

IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IEMS	Indiana Emergency Medical Service.
IEP	Individual Education Program (in relation to the First Steps Early Intervention System).
IFSP	Individual Family Service Plan (in relation to the First Steps Early Intervention System).
IFSSA	Indiana Family and Social Services Administration.
IHCP	Indiana Health Coverage Program.
IMCA	Indiana Motor Carrier Authority.
IMCS	Indiana Motor Carrier Services.
IMD	Institutions for mental disease.
IMF	Indiana Medical Foundation. Non-profit organization contracted by the DHS for the daily review and correction of abstracts submitted by all IHCP hospitals in Indiana.
IMFCU	Indiana Medicaid Fraud Control Unit.
IMRP	Indiana Medical Review Program. Program administered by the IMF to insure the medical necessity of hospitalization and surgery.
indemnity insurance	Insurance product in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. See also *Fee-for-Service*.
Indiana Family and Social Service Administration (IFSSA)	The State agency responsible for the coordination and administration of social service programs in the state of Indiana. The OMPP, under Indiana Family and Social Security Administration (IFSSA), is the single State agency responsible for the administration of the IHCP.
Indiana State Department of Health (ISDH)	The State agency responsible for promotion of health; providing guidance on public health issues; ensuring the quality of health facilities and programs and the administration of certain health programs. The Bureau of Family Health Services is the bureau within the Indiana State Department of Health (ISDH) organization charged with the administration of the Children's Special Health Care Services Division (CSHCS) as well as the Maternal and Child Health Division (MCH) and the Division of Women, Infants, and Children (WIC).
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
inquiry	Type of online screen programmed to display rather than enter information. Used to research information about members, providers, claims adjustments and cash transactions.

institution	An entity that provides medical care and services other than that of a professional person. A business other than a private doctor or a pharmacy.
intensive care	Level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
interim	A billing that is only for a portion of the patient's continuous complete stay in an inpatient setting.
intermediary	Private insurance organizations under contract with the government handling Medicare claims from hospitals, skilled nursing facilities, and home health agencies.
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
IPA	Individual Practice Associate. Model HMO. A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
IPAS	Indiana Pre-Admission Screening.
IPP	Individualized Program Plan..
IRS	Identical, related, or similar drugs, in relation to less than effective (LTE) drugs.
ISBOH	Indiana State Board of Health; currently known as the Indiana State Department of Health.
ISDH	Indiana State Department of Health; previously known as Indiana State Board of Health.
ISETS	Indiana Support Enforcement Tracking System.
ISMA	Indiana State Medical Association.
itemization of charges	A breakdown of services rendered that allows each service to be coded.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.
Julian Date	A method of identifying days of the year by assigning numbers from 1 to 365 (or 366 on leap years) instead of by month, week, and day. For example, January 10 has a Julian date of 10 and December 31 has a Julian date of 365. This date format is easier and quicker for computer processing.
L	Liter.
LAN	Local area network.

LCL	Lower Control Limit (Pertaining to quality control charts).
LCN	Letter control number.
LCSW	Licensed Clinical Social Worker.
licensed practical nurse	LPN.
limited license practitioner	LLP.
line item	A single procedure rendered to a member. A claim is made up for one or more line items for the same member.
LLP	Limited license practitioner.
LMFT	Licensed Marriage and Family Therapist.
LMHC	Licensed Mental Health Counselor.
LOA	Leave of absence.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
location	Location of the claim in the processing cycle such as paid, suspended, or denied.
lock-in	Restriction of a member to particular providers, determined as necessary by the State.
lock-out	Restriction of providers, for a time period, from participating in a portion or all of the IHCP due to exceeding standards defined by the department.
LOS	Length of stay.
LPN	Licensed Practical Nurse.
LSL	Lower specification limit, pertains to quality control charts.
LSW	Licensed Social Worker.
LTC	Long-term care. Used to describe facilities that supply long-term residential care to members.
LTE	Less than effective drugs.
M/M	Medicare/Medicaid.
MAC	Maximum allowable cost for drugs as specified by the federal government.
MAC	Monitored anesthesia care

managed care	System where the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuring quality in a cost efficient manner. See also *Section 1915(b), HMO, PPO, Primary Case Management.*
Managed Care PCCM	Members in the primary care case management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.
Managed Care RBMC	In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCO's network. The care of members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists and other providers of care, who contract directly with the MCO.
mandated or required services	Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services include the following: Hospital (IP & OP), lab/x-ray, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinic, certain nurse practitioners, federally qualified health centers, renal dialysis services, HealthWatch/EPSDT (under age 21), medical transportation.
manual claim	Claim for services submitted on a paper claim form rather than via electronic means; also seen as *paper* and *hard copy*.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCCA	Medicare Catastrophic Coverage Act of 1988.
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also *HMO, Prepaid Health Plan.*
MCPD	A pilot program that was available in Marion county from January 1997 through December 1999. It was a voluntary risk-based managed care program for IHCP enrollees that were considered disabled or chronically ill according to the State's established criteria.
MCS	Managed Care Solutions (now called Lifemark Corporation).
MD	Medical Doctor.
MDS	Minimum data set.
Medicaid	A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.

Medicaid certification	The determination of a member's entitlement to Medicaid benefits and notification of that eligibility to the agency responsible for Medicaid claims processing.
Medicaid Financial Report	State Form 7748, used for cost reporting.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
Medicaid plan	See also *Medicaid State Plan, Single State Agency.*
Medicaid Select	A managed care program for the aged, blind and disabled population consisting of a Primary Care Case Management (PCCM) delivery system.
Medicaid State plan	See also *Single State Agency, Medicaid Plan.*
Medicaid-Medicare eligible	Member who is eligible for benefits under both Medicaid and Medicare. Members in this category are *bought-in* for Part B coverage of the Medicare Program by the Medicaid Program.
medical emergency	Defined by the American College of Emergency Physicians as a medical condition manifesting itself by symptoms of sufficient severity that the abscence of immediate medical attention could reasonable be expected to result in: (a) placing health in jeopardy; (b) serious impairment to bodily function; (c) serious dysfunction of any bodily organ or part; or (d) development or continuance of severe pain.
medical necessity	The evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.
medical policy	Portion of the claim processing system whereby claim information is compared to standards and policies set by the state for the IHCP.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
medical supplies	Supplies, appliances, and equipment.
medically needy	Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.
Medicare	The federal medical assistance program described in Title XVIII of the Social Security Act for people over the age of 65, for persons eligible for Social Security disability payments and for certain workers or their dependents who require kidney dialysis or transplantation.
Medicare crossover	Process allowing for payment of Medicare deductibles and/or co-insurance by the Medicaid program.

Medicare deductibles and co-insurance	All charges classified as deductibles and/or coinsurance under Medicare Part A or Part B for services authorized by Medicare Part A or Part B.
member	A person who receives a IHCP service while eligible for the IHCP. People may be IHCP-eligible without being IHCP members. These individuals are called enrollees or members when in the Hoosier Healthwise Progam. See also *Client, Eligible Member*.
member relations	The activity within the single state agency that handles all relationships between the IHCP and individual member.
member restriction	A limitation or review status placed on a recipient that limits or controls access to the IHCP to a greater extent than for other nonrestricted members.
mental disease	Any condition classified as a neurosis, psychoneurosis, psychopathy, psychosis, or personality disorder.
mental illness	A single severe mental disorder, excluding mental retardation, or a combination of severe mental disorders as defined in the latest edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*.
mental retardation	Significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
menu	Online screen displaying a list of the available screens and codes needed to access the online system.
MEQC	Medicaid eligibility quality control.
MFCU	Medicaid Fraud Control Unit.
MHS	Managed Health Services.
MI	Mental illness.
MI/DD	Mental illness and developmental disability.
microfiche	Miniature copies of the RAs that can store approximately 200 pages of information on a plastic sheet about the size of an index card.
microfilm	Miniature copies of all claims received by Medicaid stored on film for permanent records-keeping and referral.
misutilization	Any usage of the IHCP by any of its providers or members not in conformance with both state and federal regulations, including both abuse and defects in level and quality of care.
Ml	Milliliter.
MLOS	Mean Length of Stay.
MMDDYY	Format for a date to be reflected as month, day, and year such as 091599.

MMIS	Medicaid Management Information System. Indiana's current MMIS is referred to as Indiana*AIM*.
MMRT	Medicaid Medical Review Team.
MOC	Memorandum of Collaboration; a Hoosier Healthwise document that provides a formal description of the terms of collaboration between the primary medical provider (PMP) and the preventive health care service provider (PHCSP). It also serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
MOC	Memoranda of Collaboration. For example, a Hoosier Healthwise document that provides a formal description of the terms of collaboration between a PMP and PHCSP, and serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
module	A group of data processing and/or manual processes that work in conjunction with each other to accomplish a specific function.
MR/DD	Mental retardation and developmentally disabled.
MRN	Medicare Remittance Notice. A form provided by Indiana*AIM* and sent to members. The MRN details the payment or denial of claims submitted by providers for services provided to members.
MRO	Medicaid Rehabilitation Option. Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.
MRT	Medical Review Team, unit which makes decision regarding Disability Determination.
MS	Mail stop.
MSN	Master of Science in Nursing.
MSS	Master of Social Sciences.
MSW	Master of Social Work.
MWU	Medicaid Waiver Unit, the IDDARS unit which manages the HCBS Waiver Programs.
NAS	Non-ambulatory service.
NASW	National Association of Social Workers.
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.
NDDF	National Drug Data File.

NEC	Not elsewhere classified.
NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to on-line, real-time eligibility information.
Network Model HMO	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his or her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.
NF	Nursing facility; also seen as ECF, NH, and LTC.
NH	Nursing home; also seen as ECF, NF, and LTC.
NIH	National Institutes of Health.
NOC	Not otherwise classified.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
non-core services	Refers to *Service Packages #2 and #3*.
NOOH	Notice of Opportunity for Hearing. Notification that a drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the *Federal Register* on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications.
NPIN	National provider identification number.
nursing facilities	Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) Long Term Care Program. See also *Long Term Care, TILE.*
nursing facility waiver (NF waiver)	A waiver of the Medicaid's state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to adults as an alternative to nursing facility care. See also *Nursing Facilities, 1915(c), Waiver.*
OASDI	Old Age, Survivors and Disability Insurance. See also *Title II Benefits (Social Security or OASDI).*
OB/GYN	Obstetrician/Gynecologist.
OBRA	Omnibus Budget Reconciliation Act.
OBRA-90	Omnibus Budget Reconciliation Act of 1990.
OCR	Optical Character Recognition Equipment. A device that reads letters or numbers from a page and converts them to computerized data, bypassing data entry.

OD	Doctor of Optometry.
OFC	Office of Family and Children.
OIG	Office of the Inspector General.
OMNI	A point-of-sale device used by providers to scan member ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning.
optional services or benefits	More than 30 different services that a state can elect to cover under a state Medicaid plan. Examples include personal care, rehabilitative services, prescribed drugs, therapies, diagnostic services, ICF-MR, targeted case managed, and so forth.
OTC	Over the counter, in reference to drugs.
other insurance	Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.
other processing agency	Any organization or agency that performs IHCP functions under the direction of the single state agency. The single state agency may perform all IHCP functions itself or it may delegate certain functions to other processing agencies.
outcome measures	Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.
outcomes	Results achieved through a given health care service, prescription drug use, or medical procedure.
outcomes management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying, often in a formal program of continuous quality improvement.
outcomes research	Studies aimed at measuring effect of a given product, procedure, or medical technology on health or costs.
outlier	An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.
out-of-state	Billing for a IHCP member from a facility or physician outside Indiana or from a military facility.
outpatient services	Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.
overpayment	An amount included in a payment to a provider for services provided to a IHCP member resulting from the failure of the contractor to use available information or to process correctly.

override	Forced bypassing of a claim due to error (or suspected error), edit, or audit failure during claims processing. Exempted from payment pending subsequent investigation not to be in error.
overutilization	Use of health or medical services beyond what is considered normal.
PA	Prior authorization. Some designated IHCP services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
paid amount	Net amount of money allowed by the IHCP.
paid claim	Claim that has had some dollar amount paid to the provider, but the amount may be less than the amount billed by the provider.
paid claims history file	History of all claims received by IHCP that have been handled by the computer processing system through a terminal point. Besides keeping history information on paid claims, this file also has records of claims that were denied.
paper claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as *hard copy* and *manual*.
paperless claims	Claims sent by electronic means; equivalent to EMC, ECS, ECC, and similar terms denoting claim transmittal via electronic media.
parameter	Factor that determines a range of variations.
Part A	Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. See also *Medicare, Beneficiary*.
Part B	Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also *Medicare, SMIB, Buy-In.*
participant	One who participates in the IHCP as either a provider or a member of services.
participating members	Individuals who receive Title XIX services during a specified period of time.
participating providers	Providers who furnish Title XIX services during a specified period of time.
participation agreement	A contract between a provider of medical service and the state that specifies the conditions and the services the facility must provide to serve IHCP members and receive reimbursement for those services.

PAS	Pre-admission screening. A nursing home and community-based services program implemented on January 1, 1987, that is designed to screen a member's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.
PAS Form 4B	Pre-Admission Screening Notice of Assessment Determination form.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
payouts	Generate payments to providers for monies owed to them that are not claim related. Payouts are done as the result of cost settlements or to return excess refunds to the provider.
PC	Personal computer.
PCA	Physician's Corporation of America. An HMO providing health benefits to Medicaid clients.
PCCM	Members in the Primary Care Case Management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.
PCN	Primary care network.
PCP	Primary Care Provider.
PCP	Primary care physician. A physician the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.
PDD	Professional data dimensions.
PDR	Provider Detail Report/Provider Desk Review.
peer	A person or committee in the same profession as the provider whose claim is being reviewed.
peer review	An activity by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally-accepted standards.
PEN	Parenteral and enteral nutrition .
pending (claim)	Action of postponing adjudication of a claim until a later processing cycle.
per diem	Daily rate charged by institutional providers.
performing provider	Party who actually performs the service/provides treatment.

PERS	Personal emergency response system, an electronic device which enables the consumer to secure help in an emergency.
personal care	Optional Medicaid benefit that allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living (for example, bathing, dressing, feeding, grooming). Indiana provides Primary Home Care Services under this option. See also *Primary Home Care*.
PET	Positron Emission Tomography.
PGA	Peer group average.
PHC	Primary home care. IHCP-funded community care that provides personal care services to over 40,000 aged or disabled people in Indiana. PHC is provided as an optional state plan benefit. See also *Personal Care*.
PHCSP	Preventive health care services provider; a provider of well-child care, pre-natal care services, or care coordination services.
PHO	Physician hospital organization.
PHP	Prepaid health plan. A partially capitated managed care arrangement in which the managed care company is at risk for certain outpatient services. See also *VISTA*.
physician hospital organization	An organization whose board is composed of physicians, but with a hospital member, formed for the purpose of negotiating contracts with insurance carriers and self-insured employers for the provision of health care services to enrollees by the hospital and participating members of the hospital's medical staff.
PKU	Phenylketonuria.
Plan of Care	A formal plan developed to address the specific needs of an individual. It links clients with needed services.
PM/PM	Per member per month. Unit of measure related to each member for each month the member was enrolled in a managed care plan. The calculation is as follows: # of units/member months (MM).
PMF	Provider master file.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to IHCP members assigned to the PMP's care.
pool (risk pool)	A defined account (for example, defined by size, geographic location, claim dollars that exceed **x** level per individual, and so forth) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.
POS	Place of service or point of sale, depending on the context.

PPO	Preferred provider organization. An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also *Exclusive Provider Organization (EPO).*
PR	Provider relations.
practitioner	An individual provider. One who practices a health or medical service profession.
Premium	Due from member in order to be eligible for Package C.
pre-payment review	Provider claims suspended temporarily for dispositioning and manual review by the HCE SUR Unit.
prescription medication	Drug approved by the FDA that can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.
preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care.
pricing	Determination of the IHCP allowable.
primary care	Basic or general health care traditionally provided by family practice, pediatrics, and internal medicine.
prime contractor	Contractor who contracts directly with the State for performance of the work specified.
print-out	Reports and information printed by the computer on data correlated in the computer's memory.
prior authorization	An authorization from the IHCP for the delivery of certain services. It must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances. Examples of such services are abortions, goal-directed therapy, and EPSDT dental services.
Prior Authorization or Prior Review and Approval	The procedure for the office's prior review and authorization, modification, or denial of payment for covered medical services and supplies within IHCP allowable charges. It is based on medical reasonableness, necessity, and other criteria as described in the *IAC Covered Services Rule* and *Medical Policy Rule* found in the *Appendix* to this manual.
private trust	Trust fund available to pay medical expenses.
PRO	Peer review organization.
procedure	Specific, singular medical service performed for the express purpose of identification or treatment of the patient's condition.

procedure code	A specific identification of a specific service using the appropriate series of coding systems such as the CDT, CPT, HCPCS, or ICD-9-CM.
processed claim	Claim where a determination of payment, nonpayment, or pending has been made. See also *Adjudicated Claim*.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all federal Pro-DUR requirements and all DUR requirements.
profile	Total view of an individual provider's charges or a total view of services rendered to a member.
program director	Person at the contractor's local office who is responsible for overseeing the administration, management, and daily operation of the MMIS contract.
prosthetic devices	Devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb.
provider	Person, group, agency, or other legal entity that is enrolled as a provider of services and provides a covered IHCP service to an IHCP member.
Provider Agreement	A contract between a provider and the OMPP setting out the terms and conditions of a provider's participation in the IHCP. It must be signed by the provider prior to any reimbursement for providing covered services to members.
provider enrollment application	Required document for all providers who provide services to IHCP members.
provider manual	Primary source document for IHCP providers.
provider networks	Organizations of health care providers that service managed care plans. Network providers are selected with the expectation they deliver care inexpensively, and enrollees are channeled to network providers to control costs.
provider number	Unique individual or group number assigned to practitioners participating in the IHCP.
provider relations	Function or activity within that handles all relationships with providers of health care services.
provider type	Classification assigned to a provider such as hospital, doctor or dentist.
PSRO	Professional standards review organization.
purged	Claims are removed from history files according to specific criteria after 36 months from the claim's last financial date. Claims data is online for up to 36 months.
QA	Quality assurance.
QARI	Quality Assurance Reform Initiative. Guidelines established by the federal government for quality assurance in Medicaid managed care plans.

QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QM	Quality management.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
QMHP	Qualified mental health professional.
QMRP	Qualified mental retardation professional.
quality improvement	A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement.
QUCR	Quarterly Utilization Control Reports.
query	An inquiry for specific information not supplied on standardized reports.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
Rate-Setting Contractor	An entity under contract with the OMPP to perform rate-setting activities.
RBA	Room and Board Assistance.
RBMC	In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCO's network. The care of members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists and other providers of care, who contract directly with the MCO.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
reasonable charge	Charge for health care services rendered that is consistent with efficiency, economy, and quality of the care provided, as determined by the OMPP.
reasonable cost	All costs found necessary in the efficient delivery of needed health services. Reasonable cost is the normal payment method for Medicare Part A.
recidivism	The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.
Red Book	Listing of the average wholesale drug prices.
referring provider	Provider who refers a member to another provider for treatment service.

regulation	Federal or state agency rule of general applicability designed and adopted to implement or interpret law, policy, or procedure.
reimbursement	Payment made to a provider, pursuant to Federal and State law, as compensation for providing covered services to members.
reinsurance	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. See also *Stop-Loss Insurance.*
rejected claim	Claim determined to be ineligible for payment to the provider, contains errors, such as claims for noncovered services, ineligible provider or patient, duplicate claims, or missing provider signature. Returned to the responsible provider for correction and resubmission prior to data entry into the system.
related condition	Disability other than mental retardation which manifests during the developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (for example, self-care, expressive/receptive language, learning, mobility, self-direction, and capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other diagnoses, are said to be related to mental retardation in their effect upon the individual's functioning.
remittance advice (RA)	Comprehensive billing information concerning the member disposition of a provider's submitted IHCP claims.
Remittance and Status Report (R/A)	A computer report generated weekly to a provider to inform the provider about the status of finalized and pending claims. The R/A includes EOB codes that describe the reasons for claim cutbacks, and denials. The provider receives a check enclosed in the R/A when claims are paid.
rendering provider	A provider employed by a clinic or physician group that provides service as an employee. The employee is compensated by the group and therefore does not bill directly.
rep	Provider relations representative.
repayment receivables	Transaction established in the Cash Control System when a provider has received payment to which he was not entitled.
report item	Any unit of information or data appearing on an output report.
required field	Screen field that must be filled to display or update desired information.
resolution	Step taken to correct an action that caused a claim to suspend from the system.
resolutions	The area within the processing department responsible for edit and audit correction.
Retro-DUR	Retrospective Drug Utilization Review.
RFI	Request for Information.
RFP	Request for Proposals.

RHC	Rural health clinic
RID	Recipient Identification (ID) number; the unique number assigned to a member who is eligible for IHCP services.
risk contract	An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also *MCO, Pool, Risk Pool*.
RN	Registered Nurse.
RNC	Registered Nurse Clinician.
route	Transfer of a claim to a certain area for special handling and review.
routine	A condition that can wait for a scheduled appointment.
RPT	Registered physical therapist.
RPTS	Research Project Tracking System.
RR	Resident review.
RUG	Resource Utilization Group.
rural health clinic	Any agency or organization that is a rural health clinic certified and participating under Title XVIII of the Social Security Act and has been designated by DHS as a Title XIX rural health clinic.
RVS	Relative value study. A procedure coding structure for all medical procedures, based on the most common procedure used, that assigns relative value units to medical procedures according to the degree of difficulty.
RVU	Relative value unit.
SA/DE	State Authorization/Data Entry.
SBOH	State Board of Health; previous term for the State Department of Health.
SCP	Specialty care physicians.
screening	The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive examination or treatment.
SD	Standard deviation.
SDA	Standard dollar amount.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
SED	Seriously emotionally disturbed.
SEH	Seriously emotionally handicapped.

selective contracting	Option under Section *1915(b)* of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.
SEPG	Software Engineering Process Group.
service date	Actual date on which a service(s) was rendered to a particular member by a particular provider.
service limits	Maximum number of service units to which a member is entitled, as established by the IHCP for a particular category of service. For example, the number of inpatient hospital days covered by the IHCP might be limited to no more than 30 days.
SG	Steering group.
shadow claims	Reports of individual patient encounters with a managed care organization's (MCO's) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.
SI/IS	Severity of illness/intensity of services.
SIPOC	System map outlining suppliers, inputs, processes/functions, outputs, and customers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SMI	Severely mentally ill.
SMI	Supplemental medical insurance, Part B of Medicare.
SNF	Skilled nursing facility.
SOBRA	Sixth Omnibus Budget Reconciliation Act.
SOBRA	Omnibus Budget Reconciliation Act of 1986.
SPC	Statistical process control.
special vendors	Provide support to IHCP business functions but the vendors are not currently Medicaid fiscal agents.
specialty	Specialized practice area of a provider.
specialty certification	Certification or approval by professional academy, association, or society that designates this provider has demonstrated a given level of training or competence and is a fellow or specialist.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.

Spend-down	Process whereby IHCP eligibility may be established if an individual's income is more than that allowed under the State's income standards and incurred medical expenses are at least equal to the difference between the income and the medically needy income standard.
SPMI	Severe and persistent mental illness.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSCN	Social security claim number. Account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is a social security account number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (for example, wife, widow, child, and so forth). The SSCN is the number that must be used in the Buy-In program. A beneficiary can have his own SSN but be receiving benefits under a different claim number.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
SSN	Social Security Account Number. The number used by SSA throughout a wage earner's lifetime to identify his or her earnings under the Social Security Program. This account number consists of nine figures generally divided into three hyphenated sets, such as 000-00-0000. The account number is commonly known as the Social Security Number. The number is not to be confused with Social Security Claim Number.
SSP	State Supplement Program. State-funded program providing cash asssistance that supplements the income of those aged, blind, and disabled individuals who are receiving SSI (or who, except for income or certain other criteria, would be eligible for SSI).
SSRI	Selective Serotonin Re-uptake Inhibitor.
Staff Model HMO	Health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
standard business	Health care business within the private sector of the industry, such as Blue Cross and Blue Shield.
State	Spelled as shown, State refers to the state of Indiana and any of its departments or agencies.
State fiscal year	A 12-month period beginning July 1 and ending June 30.
State Form 11971	See *8A.*
State Form 7748	Medicaid Financial Report, used for cost reporting.
State Medicaid Office	Office of Medicaid Policy and Planning, within the Family and Social Services Administration, responsible for administering the IHCP in Indiana.

State Plan	The medical assistance plan of Indiana as approved by the Secretary of Health, Education and Welfare in accordance with provisions of Title XIX of the Social Security Act, as amended.
status	Condition of a claim at a given time; such as paid, pended, denied, and so forth.
stop-loss insurance	Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance: (1) Specific or individual-reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as $25,000 or $50,000; (2) Aggregate-reimbursement is given for claims which in total exceed a predetermined level, such as 125 percent of the amount expected in an average year. See also *Reinsurance*.
subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.
submission	The act of a provider sending billings to EDS for payment.
subsystem	A Medicaid term that refers to one of the following (I)HIS processing components: member's subsystem, provider subsystem, claims processing subsystem, reference file subsystem, surveillance and utilization review subsystem, and management and administrative reporting subsystem.
SUR	Surveillance and Utilization Review. Refers to system functions and activities mandated by the Centers for Medicare and Medicaid Services (CMS) that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR requirements: Statistical analysis Exception processing Provider and member profiles Retrospective detection of claims processing edit and audit failures and errors Retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards Retrospective detection of fraud and abuse by providers or members Sophisticated data and claim analysis including sampling and reporting General access and processing features General reports and output
Survey Agency	The ISDH is the designated survey agency responsible for surveying, monitoring, reviewing, and certifying institutional providers of service who request or agree to participate in the IHCP. The ISDH also certifies several other provider types. These types are discussed under the section titled; *State, County Contractor Responsibilities* included in this chapter.
suspended transaction	A suspended transaction requires further action before it becomes a paid or denied transaction, usually because of the presence of error(s).

suspense file	Computer file where various transactions are placed that cannot be processed completely, usually because of the presence of an error condition(s).
systems analyst or engineer	Responsible for performing the following activities: Detailed system and program design System and program development Maintenance and modification analysis and resolution User needs analysis User training support Development of personal IHCP knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TBI	Traumatic brain injury.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982. The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program.
TEFRA 134(a)	Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain disabled children.
therapeutic classification	Code assigned to a group of drugs that possess similar therapeutic qualities.
third party	An individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for, or member of, medical assistance under Title XIX.
third-party resource	A resource available, other than from the department, to an eligible member for payment of medical bills. Includes, but is not limited to, health insurance, workmen's compensation, liability, and so forth.
Title I	The Old Age Assistance Program that was replaced by the Supplemental Security Income program (SSI).
Title II	Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI).
Title IV-A	AFDC, WIN Social Services.
Title IV-B	Child Welfare.
Title IV-D	Child Support.
Title IV-E	Foster Care and Adoption.
Title IV-F	Job Opportunities and Basic Skills Training.
Title V	Maternal and Child Health Services.
Title X	Aid to the Blind program (AB) replaced by the SSI.

Title XIV	Permanently and Totally Disabled program (PTD) replaced by the SSI.
Title XIX	Provisions of Title 42, United States code Annotated Section 1396-1396g, including any amendments thereto.
Title XIX Hospital	Hospital participating as a hospital under Medicare, that has in effect a utilization review plan (approved by DHS) applicable to all recipients to whom it renders services or supplies, and which has been designated by DHS as a Title XIX hospital; or a hospital not meeting all of the requirements of Subsection A.5.1.0.0.0 of the RFP but that renders services or supplies for which benefits are provided under Section 1814 (d) of Medicare or would have been provided under such section had the recipients to whom the services or supplies were rendered been eligible and enrolled under part A of Medicare, to the extent of such services and supplies only, and then only if such hospital has been approved by DHS to provide emergency hospital services and agrees that the reasonable cost of such services or supplies, as defined in Section 1901 (a) (13) of title XIX, shall be such hospital's total charge for such services and supplies.
Title XV	ISSI.
Title XVI	The SSI.
Title XVIII	The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B); the provisions of Title 42, United States Code Annotated, Section 1395, including any amendments thereto.
TPL	Third Party Liability. A client's medical payment resources, other than Medicaid, available for paying medical claims. These resources generally consist of public and private insurance carriers.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services.*
TPN	Total Parenteral Nutrition.
TQM	Total Quality Management.
trend	Measure of the rate at which the magnitude of a particular item of date is changing.
TRICARE	Formerly known as the Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS); health-care plan for active duty family members, military retirees, and family members of military retirees.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UCL	Upper control limit, pertaining to quality control charts.
UCR	Usual, customary, and reasonable charge by providers to their most frequently billed nongovernmental third party payer.
UM	Utilization management.

unit of service	Measurement divisions for a particular service, such as one hour, one-quarter hour, an assessment, a day, and so forth.
UPC	Universal product code. Codes contained on the first data bank tape update or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
UR	Utilization Review. A formal assessment of the medical necessity, efficiency, or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
urgent	Defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for the next day or a scheduled appointment.
user	Data processing system customer or client.
USL	Upper specification limits, pertaining to quality control charts.
USPHS	United States Public Health Service.
utilization	The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.
utilization management	Process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.
VA	Veterans Administration.
VFC	Vaccines for Children program.
VIP	Validation Improvement Plan.
VRS	Voice Response System, primarily seen as AVR, automated voice response system.
WAN	Wide area network.
waiver	Waiver allows members to move from the traditional Medicaid environment to a less restrictive environment. Some of the statutory entitlements are waved for the member.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children younger than five years old.
workmen's compensation	A type of third-party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which his employer's insurance company may be obligated under the Workman's Compensation Act.
Y2K	Year 2000. Commonly used in computer system compliance issues.

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